HPHC Insurance Company, Inc.

Benefit Handbook

Medicare Enhance Plan

Commonwealth of Massachusetts
Group Insurance Commission

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Medicare Enhance is a product of HPHC Insurance Company, Inc.,
a wholly owned subsidiary of Harvard Pilgrim Health Care, Inc.

Form No. 983
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NOTICE CONCERNING
MASSACHUSETTS MINIMUM CREDITABLE COVERAGE REQUIREMENTS

As of January 1, 2009, the Massachusetts Health Care Reform Law required that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This Plan is designed to provide benefits that complement the benefits provided by Medicare Parts A and B. It does not, by itself, provide comprehensive health coverage and does not meet Massachusetts Minimum Creditable Coverage standards. However, in order to be enrolled in this Plan, all Subscribers must be enrolled in both Medicare Parts A and B. **Under Massachusetts law, any individual enrolled in either Medicare Part A or Part B automatically qualifies as having health coverage that meets Minimum Creditable Coverage standards**.

In summary, Medicare beneficiaries do not need to be enrolled in this Plan, or any other Medicare complement plan, to have health coverage that meets Massachusetts Minimum Creditable Coverage requirements. Enrollment in Medicare Parts A or B is all that is required.

I. INTRODUCTION

Medicare Enhance (the "Plan") is a product of HPHC Insurance Company, Inc. ("HPIC"), a subsidiary of Harvard Pilgrim Health Care, Inc. ("Harvard Pilgrim").

This *Benefit Handbook* describes the benefits and the terms and conditions of coverage under the Plan. The Plan is designed to complement a Subscriber's Medicare coverage by:

1. Paying most Medicare Deductible and Coinsurance amounts for services covered by Medicare Parts A and B;
2. Covering certain services that Medicare does not cover at all; and
3. Paying for some Medicare-covered services after your Medicare benefits for those services have been exhausted.

To use Plan benefits, simply obtain services from any health care Provider eligible for payment by Medicare. (A few cases in which you do not need to use a Provider eligible for payment by Medicare are described in Section III.D, below.) Please see Section II of this Handbook for further information on how to use the Plan.

To understand your Medicare Enhance benefits fully, you should read the Medicare program handbook *Medicare and You*. *Medicare and You* describes your Medicare benefits in detail.

To learn more about health coverage for people with Medicare you may want to review the *Guide to Health Insurance for People with Medicare*. You may obtain Medicare publications at most Social Security Offices or by calling Medicare at **1-800-633-4227**. (TTY service is available at **1-877-486-2048**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: **http://www.medicare.gov/publications/home.asp**

Changes in Medicare benefits or the Medicare program itself may result in changes to this *Benefit Handbook*. HPIC is not responsible for notifying the GIC or Subscribers for changes in Medicare benefits or in the Medicare program. In the event such changes affect the terms and conditions of this *Benefit Handbook* or Plan benefits, the GIC will be notified and Subscribers will be sent any necessary amendment(s) to this *Benefit Handbook*.

PLEASE NOTE THAT THIS MEDICARE ENHANCE PLAN IS ONLY AVAILABLE TO SUBSCRIBERS ENROLLED THROUGH THE GIC. IF A SUBSCRIBER'S ELIGIBILITY FOR GIC COVERAGE ENDS, ENROLLMENT IN THE PLAN MUST ALSO END.

The Massachusetts Managed Care Reform Law requires disclosure of premium information and information concerning HPIC's voluntary and involuntary disenrollment rate. This information including the specific premium amount paid on your behalf by the GIC will be sent to you in a separate letter. Please keep that letter with this *Benefit Handbook* for your records.

Contacting Member Services
You may contact a Plan Member Services representative by calling **1-888-333-4742**. Deaf and hard-of-hearing Subscribers who have access to a Teletypewriter ("TTY") may communicate directly with the Member Services Department by calling **711** for TTY service.

Non-English speaking Subscribers may also call our Member Services Department at **1-888-333-4742** to have their questions answered. Harvard Pilgrim offers free language interpretation services in more than 120 languages.

The Office of Patient Protection.
The Office of Patient Protection of the Department of Public Health is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection can be reached at:

Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site: http://www.state.ma.us/dph/opp/index.htm

The following information is available to consumers from the Office of Patient Protection:

1) A list of sources of independently published information assessing Subscribers' satisfaction and evaluating the quality of health care services offered by a carrier;
2) The percentage of physicians who voluntarily and involuntarily terminated participation in contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;
3) The percentage of premium revenue expended by the carrier for health care services provided to Subscribers for the most recent year for which information is available;
4) A report detailing, for the previous calendar year, the total number of: a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

Physician Profiling Information
The Commonwealth of Massachusetts Board of Registration in Medicine maintains Internet websites with physician profiling information at **www.massmedboard.org.**

You can also write the Board of Registration in Medicine at the following address:

Board of Registration in Medicine
560 Harrison Avenue
Suite G4
Boston, MA 02118

(617) 654-9800

Pre-existing Conditions
The Plan does not impose any restrictions, limitations, or exclusions on your benefits that are related to preexisting conditions.

[Spanish]

Los miembros que no dominan el inglés pueden llamar al Departamento de servicios para miembros de Harvard Pilgrim Health Care al 1-888-333-4742, donde se responderá a sus preguntas. El Plan ofrece un servicio de interpretación gratuito en más de 120 idiomas.

[Russian]

Те, кто не владеет английским языком, могут также получить ответы на свои вопросы, позвонив по телефону 1-888-333-4742 в отдел обслуживания медицинского центра Harvard Pilgrim. Данный план предоставляет бесплатные услуги по обеспечению устного перевода более, чем на 120 иностранных языков.

[Arabic]

كما يستطيع الأعضاء الغير الناطقين باللغة الإنجليزية أن يتصلوا بقسم خدمات الأعضاء بهيئة للعناية الصحية (Harvard Pilgrim) هارفارد بيلجريم ، وذلك للحصول على 1-888-333-4742 على الرقم إجابات لاستفساراتهم. ويقدم البرنامج خدمات ترجمة مجانية بأكثر من 120 لغة.

[Portuguese]

Os membros que não falarem inglês também podem telefonar para o Departamento dos Serviços de Saúde Harvard Pilgrim para membros através do número 1 888 333 4742, de forma a obterem os esclarecimentos pretendidos. Este plano oferece serviços de interpretação gratuitos em mais de 120 idiomas.

[French]

Harvard Pilgrim Health Care propose des services d'interprétation gratuits dans plus de 120 langues pour répondre aux questions des membres qui ne parlent pas anglais. Pour utiliser ce service, appelez la section des services aux membres au 1-888-333-4742.

[Greek]

Τα Μέλη που δε μιλούν Αγγλικά μπορούν επίσης να τηλεφωνήσουν στο Τμήμα Εξυπηρέτησης Μελών του Harvard Pilgrim Health Care στον αριθμό 1-888-333-4742 για τυχόν ερωτήσεις. Το Πρόγραμμα παρέχει δωρεάν ξενόγλωσσες υπηρεσίες διερμηνείαςγια περισσότερες από 120 γλώσσες.

[Haitian Creole]

Manm yo ki pa pale Angle ka rele Depatman Sèvis Manm Harvard Pilgrim Health Care tou nan 1-888-333-4742 pou jwenn repons a keksyon yo. Plan an ofri sèvis entèpretasyon gratis nan plis ke 120 lang.

[Italian]

I Partecipanti che non parlano inglese possono anche rivolgere le proprie domande al Reparto Servizi Partecipanti dell'Harvard Pilgrim Health Care, chiamando il numero 1-888-333-4742. Il Piano offre servizi di interpretariato gratuiti in oltre 120 lingue.

[Traditional Chinese]

不說英語的會員亦可致電 1-888-333-4742，請 Harvard Pilgrim 醫療保健的 會員服務部門回答所提出的問題。該計劃免費提供120多種語言的翻譯服務。

[Lao]

ສະມາຊິກ ທັງ ຫລາຍ ທີ່ ປາກ ພາສາ ອັງກິດ ບໍ່ ເປັນ ສາມາດ ຕິດ ຕໍ່ ກັບ ພະແນກ ບໍລິການ ລູກ ຄ້າ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ **Harvard Pilgrim** ໄດ້ ໂດຍ ໄປ ຫາ **1-888-333-4742** ເພື່ອ ຂໍ ຊາບ ຄຳ ຕອບ ຂອງ ຄຳ ຖາມ ຕ່າງໆ ຂອງ ຕົນ. ໂຄງ ການ ນີ້ ຂໍ ສະເໜີ ບໍລິການ ແປ ພາສາ ໃນ ຫລາຍ ກວ່າ **120** ພາສາ ໂດຍ ບໍ່ ຄິດ ຄ່າ ບໍລິການ ໃດໆ ທັງ ສິ້ນ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស
ក៏អាចទូរស័ព្ទទៅការិយាល័យផ្នែកសេវាបំរើសមាជិកនៃ
ផែនការសុខភាព **Harvard Pilgrim**
Health Care លេខ **1-888-333-4742**
ដើម្បីឱ្យគេឆ្លើយសំនួរចំឆ្លើយផ្សេងៗ ។
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Non-English speaking Subscribers may also call the Plan's Member Services Department at **1-888-333-4742** to have their questions answered. The Plan offers free language interpretation services in more than 120 languages.

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II. ABOUT THE PLAN

A. HOW TO USE THIS BENEFIT HANDBOOK

1. THE DOCUMENTS THAT EXPLAIN YOUR COVERAGE

This *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* make up the legal agreement stating the terms and conditions of the Plan.

The *Benefit Handbook* contains most of the details of your coverage. The *Schedule of Benefits* states the Copayments and any other charges that apply to the GIC's plan. It also may be used as a brief summary of your benefits.

The Plan's coverage for prescription drugs is described in your *Prescription Drug Brochure*. It is important that you read that document to understand how to obtain medications at the lowest out-of-pocket cost to you.

In writing these documents, we have tried to provide you with all of the information you need to make full use of your benefits under the Plan. You may use these documents to learn:

- What is covered;
- What is not covered;
- Any limits or special rules for coverage;
- Any Copayments or other charges you have to pay for Covered Services; and
- Procedures for filing claims and obtaining reimbursement for services.

2. WORDS WITH SPECIAL MEANING

Some words in this *Benefit Handbook* have special meanings. When we use one of these words, we capitalize it. We list such words and what they mean in the Glossary at the end of this Handbook

3. HOW TO FIND WHAT YOU NEED TO KNOW

The *Benefit Handbook* begins with a table of contents that will help you find what you need to know.

We have also organized this *Benefit Handbook* with the most important things first. For example, the Plan's benefits are described in the next section. The list of services that are not covered, known as "exclusions," follow the description of the Plan's Benefits. Procedures for obtaining reimbursement follow the list of exclusions. As noted above, Copayments and other charges you need to pay are stated in the *Schedule of Benefits*.

4. INFORMATION ABOUT YOUR MEDICARE BENEFITS

Medicare Enhance complements the coverage you receive from the Medicare program. The information on Medicare benefits contained in this Handbook is only designed to help you make use of your benefits under the Plan. You should read the Medicare program handbook, *Medicare and You* for information on your Medicare benefits. You may obtain a copy of *Medicare and You* at most Social Security Offices and by calling Medicare at **1-800-633-4227**. (TTY service is available at **1-877-486-2048**.) A number of publications explaining Medicare benefits may be obtained on the Internet at the following web address: **http://www.medicare.gov/publications/home.asp**

5. YOUR IDENTIFICATION CARD

Each Subscriber receives an identification card. The card contains important information about your coverage. It must be presented along with your Medicare card whenever you receive health care services.

B. HOW MEDICARE ENHANCE WORKS

Medicare Enhance (the "Plan") provides GIC-sponsored health coverage for persons enrolled in Medicare Parts A and B. A Medicare-eligible Spouse or dependent of an eligible Subscriber may also be enrolled under a separate contract if he or she meets the eligibility requirements of the Plan and the GIC. The Plan complements Medicare coverage by:

- Paying most Medicare Deductible and Coinsurance amounts for services covered by Medicare;
- Covering a number of Special Services that are required to be provided under State law.

The benefits of the Plan are explained in detail in Section III, below.

To use Plan benefits, simply obtain services from any health care Provider eligible for payment by Medicare. (A few cases in which you do not need to use a Provider eligible for payment by Medicare are described in Section III.D, below.) In the case of Medicare-covered services, your health care Provider will first bill Medicare for services you receive. You or your Provider may then submit a Medicare Summary Notice (MSN) to the Plan for payment of the Medicare Deductible and Coinsurance amount. In the case of services that are not covered by Medicare, the Plan may be billed directly by either you or your Provider. Please see Section V ("Reimbursement and Claims Procedures"), below, for a detailed explanation of the Plan's claim filing procedures.

C. COVERAGE IN A MEDICAL EMERGENCY

You are always covered for care you need in a Medical Emergency. In a Medical Emergency you may obtain services from a physician, a Hospital, or a Hospital emergency room. Within the United States, you are also covered for ambulance transportation to the nearest Hospital that can provide the care you need. Please see your *Schedule of Benefits* for information on the Copayments that apply to the different types of emergency care.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number.

The Plan also provides special benefits for emergency care outside of the United States. (With very limited exceptions, Medicare does not cover any services received outside of the United States.) Please see Section III.D.3 of this Handbook for a description of the Plan's coverage for services received outside of the United States.

A Medical Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to safely transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

D. SUBSCRIBER COST SHARING AND PLAN PAYMENT LIMITS

Subscribers are required to share the cost of the benefits provided under the Plan. In some cases there may also be limits on the Plan's payments for certain services. General information about cost sharing and payment limits is set forth below. The specific cost sharing and payment limits that apply to your Plan are explained in your *Schedule of Benefits*.

a. Plan Copayments

Most cost sharing under the Plan is in the form of Copayments. Copayments are fixed dollar fees that Subscribers must pay for certain services covered by the Plan. Copayments are generally payable at the time of service.

The Copayments that apply to your Plan are listed in your *Schedule of Benefits*.

b. Limits on Payments by the Plan

The Plan has established a maximum amount it will pay for different types of Covered Services. This is called the "Payment Maximum." For services covered by Medicare, the Payment Maximum is the Medicare approved (or "allowable") amount for the service. However, Medicare Providers who do not "accept assignment" may charge somewhat more than the Medicare allowable amount. This is explained in Section V.D ("Claims for Services Covered By Medicare Part B"). The Payment Maximum may also apply to services that are not covered by Medicare. This is explained in Section V.J. ("The Payment Maximum") Plan Deductible.

E. ACCESS TO INFORMATION AND CONFIDENTIALITY

The Subscriber agrees that, except where restricted by law, the Plan may have access to (1) all health records and medical data from health care Providers providing services covered under this *Benefit Handbook*, and (2) information concerning health coverage or claims from all Providers of motor vehicle insurance, medical payment policies, homeowners insurance and all types of health benefit plans.

The Plan is committed to ensuring and safeguarding the confidentiality of its Subscribers' information in all settings, including personal and medical information. The Plan staff access, use and disclose Subscriber information only in connection with providing services and benefits and in accordance with The Plan's confidentiality policies. The Plan permits only designated employees, who are trained in the proper handling of Subscriber information, to have access to and use of your information. The Plan sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to the Plan's confidentiality and privacy standards.

When you enrolled in the Plan, you consented to certain uses and disclosures of information which are necessary for the provision and administration of services and benefits, such as: coordinating care; conducting quality activities, including Subscriber satisfaction surveys and disease management programs; verifying eligibility; fraud detection; and certain oversight reviews, such as

accreditation and regulatory audits. When the Plan discloses Subscriber information, it does so using the minimum amount of information necessary to accomplish the specific activity.

The Plan discloses Subscribers' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your *Benefit Handbook*. Whenever possible, the Plan discloses Subscriber information without individual identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. The Plan will not disclose to other third parties, such as your employer, Subscriber-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable law, the Plan and all of its contracted health care providers agree to provide Subscribers with access to, and a copy of, their medical records upon a Subscriber's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

To review HPHC Insurance Company's Notice of Privacy Practices, visit www.harvardpilgrim.org (keyword: privacy) or call 888-333-4742 for a printed copy.

III. COVERED BENEFITS

A. INTRODUCTION

This section describes the products and services covered by the Plan.

The Plan covers services in conjunction with your benefits under Medicare Parts A and B. Medicare is the primary payer for Medicare-covered services. The Plan will only provide coverage for such services after your Medicare benefits have been determined. The Plan also provides coverage for a number of benefits required by State law that may not be covered by Medicare as well as coverage for additional benefits not covered by Medicare. These benefits are described in Sections III.C ("State Mandated Benefits") and III.D ("Additional Covered Services"), below and your *Schedule of Benefits*.

To be covered by the plan, a product or service must meet each of the following basic requirements:

- It must be Medically Necessary;
- It must be received while the Member is enrolled as a Subscriber in the Plan;
- It must be either covered by Medicare or listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure*; and
- It must not be listed as a product or service that is excluded from coverage by the Plan.

All coverage is subject to the Copayments listed in the *Schedule of Benefits*. Payments by the Plan are limited to the Payment Maximum described in Section V ("Reimbursement and Claims Procedures") and the Glossary. The Subscriber is responsible for any amount billed by a Provider that is in excess of the Payment Maximum for that service.

B. SERVICES COVERED BY MEDICARE

This section describes your benefits for services that are covered by the Medicare program. The Plan covers the Medicare Deductible and Coinsurance amounts for all services covered by Medicare Parts A and B. All coverage is subject to the Subscriber Copayments stated in the *Schedule of Benefits*. In all cases, the decision of the Medicare program to provide coverage for a service must have been made before any Plan benefits will be payable under this section. No coverage will be provided by the Plan for any service denied by Medicare unless the service is specifically listed in Sections III.C or III. D, below.

The following is a summary of the services covered by Medicare Parts A and B. (Please see "*Medicare and You*" for additional information on Medicare coverage.) When Medicare Parts A and B covers a service but does not pay the full amount, the Plan covers the applicable Medicare Coinsurance and Deductible amounts up to the Payment Maximum, less any Plan copayment.

1. INPATIENT SERVICES

a. Hospital Care

Medicare coverage for inpatient Hospital care is determined by Benefit Periods. There is no limit to the number of Benefit Periods covered by Medicare during your lifetime. However, Medicare benefits for inpatient Hospital care are limited to 90 days during a Benefit Period. If you exhaust the 90-day limit during a Benefit Period, you can elect to use up to 60 additional days of inpatient Hospital care during that Benefit Period from your Medicare "lifetime reserve days." These are non-renewable days of hospital coverage that you may use only once in your life.

Most hospital care covered by Medicare may be obtained at any Medicare-certified Hospital, including a psychiatric hospital. However, certain services including liver, lung, heart, heart-lung, pancreas and intestine transplants and bariatric surgery must be obtained at a Hospital that has been approved by Medicare for the specific type of surgery required. These Hospitals are required to meet strict quality standards. If Medicare requires that a service be provided at a Hospital specifically approved for the service, neither Medicare nor the Plan will provide any coverage if the service is obtained at an unapproved Hospital.

If you exhaust the 190-day Medicare limit for inpatient services in a psychiatric hospital, you may be eligible for additional coverage for inpatient care beyond the Medicare limit. See Section III.D.1. below.

The Plan will provide the following coverage in connection with semi-private room and board and Special Services for Medicare-covered inpatient Hospital services:

i. **Deductible:** The Plan will pay the Medicare Part A Deductible amount applicable to the 1st day of hospitalization through the 60th day of hospitalization in each Benefit Period.

ii. Coinsurance: The Plan will pay the Medicare Part A daily Coinsurance amount from the 61st day of hospitalization through the 90th day of hospitalization in each Benefit Period.

iii. Lifetime Reserve Days Coinsurance: The Plan will pay the Medicare lifetime reserve days daily Coinsurance amount from the 91st day of hospitalization in each Benefit Period for each of the 60 Medicare lifetime reserve days used.

Benefits for Non-Medicare-covered Hospital Services. The Plan provides coverage for Hospital care in excess of the Medicare limits described above, which is listed in Section III.D ("Additional Covered Services") and your *Schedule of Benefits*.

b. Care in a Skilled Nursing Facility (SNF)

The Plan covers the Medicare Deductible and Coinsurance amounts for Medicare-covered care in a Skilled Nursing Facility (SNF). Medicare covers up to 100 days per Benefit Period in a Medicare-certified SNF. To be eligible for coverage, all rules applicable to Medicare coverage of SNF care must be met. These include the following:

- The Subscriber needs skilled nursing or rehabilitative care;
- The care is required on a daily basis;
- The care can, as a practical matter, only be provided in an inpatient setting; and
- The Subscriber must have been an inpatient in a Hospital for at least three days and enter the SNF within 30 days after Hospital discharge.

There is no coverage for care received in a SNF that does not meet Medicare coverage rules, including the requirements stated above.

The following is a description of the coverage provided by the Plan for care in a Medicare-certified SNF:

i. First 20 Days: Medicare covers from the 1st day of inpatient services through the 20th day of inpatient services in each Benefit Period. No coverage is provided by the Plan.

ii. Coinsurance: The Plan will cover the Medicare Part A daily Coinsurance amount for a semi-private room and board and Special Services from the 21st day of inpatient services through the 100th day of inpatient services in each Benefit Period.

c. Care in a Religious Nonmedical Health Care Institution

The Plan will cover the Medicare Part A Coinsurance and Deductible amounts for inpatient care in a Religious Nonmedical Health Care Institution (RNHCI), such as a Christian Science Sanatorium. All Medicare conditions and limitations on the coverage of services in a RNHCI also apply to the coverage provided by the Plan. Religious aspects of care provided in RNHCIs are not covered.

2. OUTPATIENT SERVICES

a. Emergency Room Care

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered services provided at a hospital emergency room or other emergency facility, less than the Plan Emergency Room copayment.

b. Urgent Care Services

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered services provided at 1) a convenience care clinic or (2) an urgent care clinic, entitled to coverage by the Medicare program, less the applicable Plan copayment.

Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as nurse practitioners, and are located in stores, supermarkets or pharmacies.

Urgent care clinics provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care clinics are independent clinics or certain hospital-owned clinics that provide urgent care services. Urgent care clinics are staffed by doctors, nurse practitioners, and physician assistants.

Important Notice: Urgent Care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section II.C. ("Coverage in a Medical Emergency") for more information.

c. Services of Physicians and Other Health Professionals

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered services provided by physicians and other health professionals entitled to coverage by the Medicare program, less the applicable Plan copayment. Such health professionals include, but are not limited to, certified nurse-midwives, chiropractors, clinical social workers, clinical psychologists, dentists, nurse

anesthetists, nurse practitioners, occupational therapists, physical therapists, physicians' assistants, podiatrists, speech therapists, audiologists and registered dieticians. Please see Section III.B.2.l, below, for additional information on your coverage for physical, occupational and speech therapy.

Medicare coverage includes unlimited visits with mental health professionals eligible for payment by Medicare. These include physicians, clinical psychologists and clinical social workers.

Please note that very limited coverage is provided for the services of chiropractors and dentists. Medicare only covers the services of chiropractors for manual manipulation of the spine to correct a spinal subluxation. Please see Section III.B.2.n ("Dental Care and Oral Surgery") for the circumstances under which the services of a dentist may be covered.

The services of podiatrists are covered by Medicare to treat injuries and diseases of the foot. Neither Medicare nor the Plan will cover most routine foot care, such as cutting of nails, the trimming of corns and bunions or the removal of calluses. However, Medicare does cover routine foot care that is Medically Necessary due to circulatory system disease, such as diabetes.

d. Preventive Care Services

The Plan will pay the Medicare Coinsurance and Deductible amounts for all Medicare-covered preventive care services. In addition, your Plan covers a number of preventive care services not covered by Medicare. Please see Section III.D.2. ("Preventive Care Services") for the details of your coverage.

Please consult with your doctor and refer to *Medicare and You* for further information on Medicare-covered preventive services that may benefit you.

e. Diagnostic Tests and Procedures

The Plan will pay the Medicare Coinsurance and Deductible amount for Medicare-covered diagnostic laboratory tests, X-ray examinations and other diagnostic procedures.

f. Medical Therapies

The plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered therapeutic services. These include surgery, radiation therapy for cancer, and therapy for any condition for which isotopes, radium, or radon seeds are used. Also covered are chemotherapy and immunosuppressive drugs (and their administration) when such medications cannot be self-administered. (Please see your *Prescription Drug Brochure* for information on your coverage of self-administered medications.)

Medicare-covered services include post-mastectomy coverage for: (1) surgical reconstruction of the breast on which the mastectomy was performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) physical complications for all stages of mastectomy, including lymphedemas, in a manner determined by the attending physician and the patient.

g. Durable Medical Equipment and Prosthetic Devices

The plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered durable medical equipment and prosthetic devices. Medicare coverage is provided only for equipment or devices that are Medically Necessary for the treatment of illness or injury or to improve the functioning of a malformed body part.

Durable medical equipment is defined by Medicare as equipment which: (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful in the absence of illness or injury, and (4) is appropriate for use in the home. Examples of such equipment include oxygen and oxygen equipment, blood glucose monitors, hospital beds, crutches and canes.

Medicare defines prosthetic equipment as a device that replaces an internal body organ. Examples of such devices include prosthetic hands, prosthetic legs, cardiac pacemakers, prosthetic lenses, breast prostheses (including mastectomy bras) and eyeglasses or contact lenses after cataract surgery.

No coverage is provided for equipment that is not covered by Medicare, including, but not limited to, dentures or dental appliances. In addition, no coverage is provided for equipment provided by a company that is not enrolled in the Medicare program.

h. Home Health Care

Medicare provides coverage for Medically Necessary home health services if you are confined to your home. Services covered by Medicare may include intermittent skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, nutritional counseling, the services of a home health aide, medical supplies and durable medical equipment.

A Medicare-participating Home Health Agency must provide home health care services.

Since no Medicare Deductible or Coinsurance amounts apply to home health care (other than durable medical equipment), no additional coverage for home health care is provided by the Plan except that the Plan covers Medicare Coinsurance and Deductible amounts for Medicare-covered durable medical equipment furnished in connection with the home health care services. Please see Section III.B.2.g, above, for information on benefits for Durable Medical Equipment.

i. Ambulance Services

The Plan will pay the Medicare Part B Coinsurance and Deductible amount for Medicare-covered ambulance transportation. Medicare covers ambulance services only if the ambulance provider meets Medicare requirements and transportation by any other vehicle would endanger your health. In general, Medicare benefits are only provided for transportation between the following locations, (1) home and a hospital, (2) home and a skilled nursing facility (SNF), or (3) a hospital and a skilled nursing facility.

j. Hospice Care

Medicare covers hospice services for a Subscriber with a Terminal Illness, when provided by a Medicare-certified hospice. The Plan will provide coverage for Medicare Deductible and Coinsurance amounts for Medicare-covered hospice care.

k. Kidney Dialysis

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered kidney dialysis.

l. Physical, Occupational and Speech Therapy

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered physical, occupational and speech therapy, less any Plan copayment. In order to be covered by Medicare a physician must certify that: (1) the patient required the therapy, (2) a plan of care has been established, and (3) the services were provided while the patient was under the care of a physician. (Additional coverage for the diagnosis and treatment of speech, hearing and language disorders may be available for services not covered by Medicare. Please see Section III.C.7, below, for further information.)

m. Partial Hospitalization

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered partial hospitalization for mental health and drug and alcohol abuse rehabilitation. Partial hospitalization services are an acute level of care that is more intensive than traditional outpatient services, but less intensive than 24-hour care. Medicare covers partial hospitalization when inpatient care would otherwise be required. Programs providing primarily social or recreational activities are not covered.

n. Dental Care and Oral Surgery

Medicare does not cover Dental Services. However, Medicare has determined that certain services provided by dentists or oral surgeons are primarily medical in nature and therefore eligible for Medicare coverage. The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered services provided by dentists or oral surgeons, less any Plan copayment. The following are examples of services that are generally eligible for coverage by Medicare:

- The extraction of teeth to prepare the jaw for radiation treatment for neoplastic disease.
- Surgery of the jaw or related structures.
- Setting fractures of the jaw or facial bones.
- Services of a dentist that would be covered if provided by a physician, such as the treatment of oral infections and tumors.
- Dental examinations to diagnose an infection that would contraindicate surgery.
- Orthodontic and dental care related to the treatment of cleft lip or cleft palate for children under the age of 18. Please see Section III.C.10 ("Cleft Lip or Cleft Palate Care for Children") for the details of your coverage.

The Plan will pay the Medicare Coinsurance and Deductible amounts for the services of dentists and oral surgeons that have been covered by Medicare. No other Dental Services are covered.

o. Prescription Drug Coverage

The GIC has purchased coverage for outpatient prescription drugs, and that coverage is described in the *Prescription Drug Brochure* you received with this *Benefit Handbook*. The Plan provides benefits for most prescription medications, subject to the Copayments listed on your Plan ID card. The Plan's drug coverage meets Medicare Part D creditable coverage requirements. Please see the *Prescription Drug Brochure* for the details of the coverage provided.

The Plan also pays the Medicare Coinsurance and Deductible amounts for any drug covered by

Medicare Part B. **However, Medicare Part B drug coverage is very limited. Most standard outpatient drugs are not covered.**

When Medicare criteria are met, drugs covered by Medicare Part B may include: (1) injected drugs you get in a doctor's office; (2) certain oral cancer drugs; (3) drugs used with some types of Durable Medical Equipment such as a nebulizer or infusion pump; (4) Hemophilia clotting factors; (5) antigens; (6) certain immunosuppressive drugs; and (7) Erythropoitin (EPO).

This list is provided for informational purposes only and does not include all Medicare-covered drugs. Specific information on the drugs covered by Medicare Part B and the criteria for coverage must be obtained from the Medicare program.

p. Coverage for Clinical Trials

The plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered services received during participation in a clinical trial. Please see the Medicare publication "Medicare & Clinical Trials," available from the Center for Medicare and Medicaid Services (CMS), for information on the Medicare coverage requirements for clinical trials.

q. Diabetes Screening and Treatment

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered services for the screening and treatment of Diabetes, less any Plan copayment. Subject to Medicare coverage criteria, these services include, but are not limited to, the following:

- Diabetes screening;
- Diabetes self-management training;
- Diabetic laboratory tests;
- Blood sugar self-testing equipment and supplies. These include blood glucose monitors and test strips, lancet devices and lancets and glucose control solutions;
- Insulin pumps and insulin used with an insulin pump;
- Therapeutic shoes or inserts for people with severe diabetic foot disease (if certified by a physician).

Insulin (other than insulin administered with an insulin pump) is covered under the Plan's coverage for outpatient prescription drug coverage. Needles and syringes for the administration of Insulin are covered by this Plan. Please refer to Section III.C.6 of this *Benefit Handbook*.

C. STATE-MANDATED BENEFITS

This section lists additional Plan benefits that are required by Massachusetts law, which may not be covered by Medicare. If Medicare coverage is available for any service listed below, the coverage provided by the Plan is reduced by the Subscriber's Medicare benefits.

1. MENTAL HEALTH CARE AND SUBSTANCE ABUSE REHABILITATION SERVICES

The Plan provides coverage for Medicare Coinsurance and Deductible amounts for mental health and substance abuse rehabilitation services covered by Medicare. The Plan also covers additional benefits for such services that are mandated by Massachusetts law. Your Massachusetts-mandated coverage, explained in this subsection.

When Medicare coverage is available for any of the services listed below, the Plan will cover only the applicable Medicare Coinsurance and Deductible amounts. When Medicare does not cover a service listed, payment for Medically Necessary Covered Services shall be made by the Plan up to the Payment Maximum, less any Plan Copayment, as described below.

a. Covered Providers

The Medicare-covered services described in Section III.B, above, are only available from Providers who are eligible to bill Medicare for Covered Services. The Massachusetts-mandated mental health and substance abuse rehabilitation services may be obtained from any of the following types of Providers, some of whom may not be eligible for payment by Medicare.

Inpatient Care: In addition to Medicare-certified institutions, the Plan will cover the Massachusetts-mandated mental health and substance abuse rehabilitation services described in this section on an inpatient basis or in intermediate levels of care (see page 13) at a partial hospitalization program at any Inpatient Mental Health Facility in Massachusetts. An Inpatient Mental Health Facility is any one of the following types of institutions:

- A general Hospital licensed to provide such services;
- A facility under the direction and supervision of the Massachusetts Department of Mental Health;
- A private mental hospital licensed by the Massachusetts Department of Mental Health; or
- A substance abuse facility licensed by the Massachusetts Department of Public Health.

Intermediate Care Services: In addition to care at Medicare Certified institutions, the Plan will cover Massachusetts mandated intermediate care services at any of the following types of facilities in Massachusetts that are licensed or approved by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health:

- A Level III Community-Based Detoxification Facility;
- An Acute Residential Treatment Facility;
- A Partial Hospitalization Program;
- A Day Treatment Program; or
- A Crisis Stabilization Program.

Outpatient Care: The Plan will cover the Massachusetts-mandated mental health and substance abuse rehabilitation services described in this section on an outpatient basis at any of the following:

- A licensed hospital;
- A mental health or substance abuse clinic licensed by the Massachusetts Department of Public Health;
- A public community mental health center;
- A professional office; or
- Home-based services.

To be covered, a Licensed Mental Health Professional acting within the scope of his or her license must render such services. A "Licensed Mental Health Professional" is any one of the following types of providers: a licensed physician who specialized in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed nurse mental health clinical specialist; or a licensed mental health counselor.

b. Minimum Benefits for Mental Health Services

Massachusetts law provides minimum benefits for mental health services. Although Medicare provides extensive coverage for mental health services, there are some circumstances in which no Medicare coverage is available. This might happen: (1) where a Subscriber had used all of his or her Medicare-covered inpatient days (described above in Section III.B.1.a, "Hospital Care"), or (2) where a Subscriber wanted to receive care from a provider, such as a licensed Mental Health Counselor, who is not eligible for payment by Medicare. In such cases, the Plan will provide coverage, less any payments made by Medicare, for the diagnosis and treatment of all mental disorders, which are described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), as follows:

i. **Inpatient Treatment:** The Plan will cover Medically Necessary inpatient mental health treatment when provided at an Inpatient Mental Health Facility.

ii. **Outpatient Treatment:** The Plan will cover Medically Necessary outpatient mental health services rendered by a Licensed Mental Health Professional**.**

c. Special Benefits for Certain Conditions

Under the Massachusetts law special benefits are provided for the following specific mental health conditions:

i. **Biologically-Based Mental Disorders:** Biologically-based mental disorders are: (1) schizophrenia; (2) schizoaffective disorders; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; and (10) eating disorders; (11) post-traumatic stress disorders; (12) substance abuse disorders; and (13) autism.

ii. **Services Required As A Result Of Rape:** When services are required to diagnose and treat rape-related mental or emotional disorders for victims of rape or victims of an assault with the attempt to commit rape.

If you are diagnosed as having one of the specific mental conditions described above in this subsection, the Plan will cover Medically Necessary services, less any payments by Medicare, as follows:

- In the case of inpatient care, for the same number of days as the benefits available for Hospital care for a physical illness. This includes any coverage, in addition to Medicare benefits, provided by your Employer Group.
- In the case of intermediate care, to the extent Medically Necessary
- In the case of outpatient care, to the extent Medically Necessary.

d. Detoxification and Psychopharmacological Services

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered detoxification and psychopharmacological services to the extent Medically Necessary, less any Plan copayment.

e. Psychological Testing and Neuropsychological Assessment

The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare-covered psychological testing and neuropsychological assessment to the extent Medically Necessary, less any Plan copayment.

2. SPECIAL FORMULAS FOR MALABSORPTION

The Plan will provide coverage, less any payments made by Medicare, for nutritional formulas for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophogeal reflux, gastrointestinal motility, and chronic pseudo-obstruction. In order to be covered, formulas for these conditions must be ordered by a physician.

3. WIGS

The Plan will provide coverage of a scalp hair prosthesis (wig) up to the amount specified in the *Schedule of Benefits* when the treating physician provides the Plan with a written statement that the wig is Medically Necessary and needed as a result of treatment for any form of cancer or leukemia.

4. BONE MARROW TRANSPLANTS FOR BREAST CANCER

The Plan will provide coverage, less any payments made by Medicare, for autologous bone marrow transplants for metastasized breast cancer in accordance with the criteria established by the Massachusetts Department of Public Health.

5. LOW PROTEIN FOODS

The Plan covers low protein foods for inherited diseases of amino and organic acids up to the amount specified in the *Schedule of Benefits*.

6. HYPODERMIC SYRINGES AND NEEDLES

The Plan will provide coverage for hypodermic syringes and needles to the extent Medically Necessary.

You must get a prescription from your physician and present it at any pharmacy for coverage. Please see your *Prescription Drug Brochure* for details. Your prescription drug Copayments are also listed on your ID Card.

7. SPEECH-LANGUAGE AND HEARING SERVICES

The Plan will provide coverage, less any payments made by Medicare, for diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary. To be covered, services must be provided by a state licensed speech-language pathologist or audiologist.

8. CONTRACEPTIVE SERVICES AND HORMONE REPLACEMENT THERAPY

The Plan provides coverage, less any payments made by Medicare, for outpatient professional services for the prevention of pregnancy and in connection with the use of hormone replacement therapy for pre- and post-menopausal women. Such services include consultations, examinations, and procedures related to all methods of contraception that have been approved by the United States Food and Drug Administration. Please see your *Prescription Drug Brochur*e for details of the drug coverage.

9. MASSACHUSETTS-MANDATED COVERAGE FOR HOSPICE CARE

In addition to the benefit for Medicare-covered hospice care described in Section III.B.2.j, above, the Plan will cover hospice care that is not eligible for payment by Medicare, provided that the hospice provider is licensed by the Massachusetts Department of Public Health. To qualify for coverage, a Subscriber must have a Terminal Illness and receive authorization for hospice care from a licensed physician.

10. CLEFT LIP OR CLEFT PALATE CARE FOR CHILDREN

The Plan will provide coverage, less any payments made by Medicare, up to the Payment Maximum, minus any applicable Plan copayment, for the treatment of cleft lip and cleft palate for children under the age of 18, including coverage for:

- Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery;
- Orthodontic treatment;
- Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy;
- Speech therapy;
- Audiology services; and
- Nutrition services.

11. HEARING AIDS

The Plan provides coverage for Medically Necessary hearing aids including related services and supplies, for Members up to the age of 22. A hearing aid is defined as any wearable aid or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person’s hearing.

Covered Services include the following:

- Payment for the full cost of each hearing aid per hearing impaired ear up to the limit listed in your *Schedule of Benefits*;
- With the exception of batteries, any necessary parts, attachments or accessories, including ear moldings; and
- Services provided by a licensed audiologist, hearing instrument specialist or licensed physician that are necessary to assess, select, fit, adjust or service the hearing aid.

Covered Services and supplies related to your hearing aid are not subject to the dollar limit for hearing aids listed in your *Schedule of Benefits*. If you purchase a hearing aid that is more expensive than the coverage amount limit listed in your *Schedule of Benefits*, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered.

Please see Section III.D.7, of this Handbook for hearing aid coverage for Members over the age of 22.

12. ORAL MEDICATIONS FOR THE TREATEMENT OF CANCER

The Plan provides coverage, less any payments by Medicare, for certain orally administered medications for the treatment of cancer that are purchased at a pharmacy to the extent Medically Necessary. No cost sharing applies for these medications.

You must get a prescription from your physician and present it at a Plan participating pharmacy for coverage. A list of Plan participating pharmacies is available from the Member Services Department or at **www.harvardpilgrim.org**

D. ADDITIONAL COVERED SERVICES

1. NON-MEDICARE COVERED HOSPITAL SERVICES

The Plan covers Hospital care in excess of the limits on Medicare coverage summarized on Section III.B.1.a, above. If all of the conditions outlined below are met, there is no limit to the number of days of Hospital care that may be covered by the Plan beyond the last day of Medicare Hospital coverage. Benefits for Hospital care in excess of Medicare limits will only be paid by the Plan only if all of the following conditions are met: (1) the care is provided in a Medicare certified Hospital; (2) all 60 of the Subscriber's Medicare Lifetime Reserve Days have been used; (3) the Hospital services are Medically Necessary; and (4) Medicare coverage of Hospital care terminated because the Subscriber reached the day limits on Medicare-covered Hospital services and not for any other reason.

2. PREVENTIVE CARE SERVICES

This section lists the preventive care services covered by either Medicare or the Plan. In some cases, Medicare coverage may be available for part of a service, the remainder of which is covered by the plan. If Medicare coverage is available for any service listed below, the Plan will pay the Medicare Coinsurance and Deductible amount. If Medicare coverage is not available, the Plan will cover the service minus any Copayment up to the Payment Maximum.

a. Physician's Services

The Plan provides coverage, less any payments by Medicare, for the following preventive care services:

i. An annual physical examination by a licensed physician, including education in self-care, blood pressure check, Pap Test and pelvic examination, clinical breast examination, fecal occult blood test, prostate cancer screening, nutritional counseling, and routine laboratory and blood tests.

ii. The following preventive care services are covered to the extent Medically Necessary: immunizations, diabetes screenings, cholesterol measurements, glaucoma screening, prenatal and postpartum care and screenings for sexually transmitted diseases.

b. Diagnostic Tests and Procedures

The Plan or Medicare covers the following diagnostic tests, in addition to the preventive care services listed above, to the extent Medically Necessary:

i. Colorectal cancer screening, including flexible sigmoidoscopy, colonoscopy, and barium enema;

ii. Bone Mass Measurements;

iii. Vision examination limited to one routine eye exam in each 24 month period (including glaucoma screening); and

iv. An annual hearing examination.

Coverage is also provided for a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older.

3. SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

This section describes the Plan's coverage for services received outside of the United States and its territories. (Generally, Medicare only covers services received within the United States.) Please note that the Plan's

coverage is intended for persons living in the United States who travel to other countries. It is not intended for persons living outside the United States.

The Plan covers services received outside of the United States when needed to care for an unexpected Medical Emergency that takes place while traveling away from home. Covered Services include, but are not limited to, Medically Necessary emergency room care, physician services, and hospital care immediately following a Medical Emergency. Transportation by ambulance is covered only for a road ambulance from the place where a Medical Emergency takes place to the nearest hospital.

A Medical Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack; stroke; shock; major blood loss; choking; severe head trauma; loss of consciousness; seizures; and convulsions.

No benefits will be provided for any service received outside of the United States that is: (1) a routine or preventive service of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.

4. DIABETES TREATMENT

The Plan will provide coverage, less any payments made by Medicare, for:

- Outpatient diabetes self-management training;
- Diabetic laboratory tests;
- Blood glucose monitors, including coverage for voice-synthesizers and visual magnifying aids when Medically Necessary for use of blood glucose monitors for the legally blind;
- Dosage gauges, injectors, lancet devices, and molded shoes needed to prevent or treat complications of diabetes;
- Insulin pumps and infusion devices; and
- Insulin, insulin syringes, insulin pump supplies, insulin pens with syringe, oral agents for controlling blood sugar, lancets, blood test strips, and glucose, ketone, and urine test strips.

Pharmacy items are subject to the prescription Copayment listed on your ID card.

5. HOME INFUSION THERAPY

Medicare does not cover most home infusion therapies. Infusion therapy involves the administration of drugs and nutritional products that must be administered intravenously or through a feeding tube. The Plan provides coverage, less any payments made by Medicare, for the following infusion therapies administered in the Subscriber's home: (1) parenteral nutrition, (2) enteral nutrition, (3) hydration, (4) pain management, and (5) antibiotic, antifungal and antiviral therapies. Coverage includes the drug or nutritional product being infused and Medically Necessary professional services, including mid-line and PICC line insertions.

In order to be covered under this benefit (1) all products and services must be Medically Necessary and (2) there must be a medical reason that appropriate drugs or nutritional products cannot be taken orally. Coverage by the Plan is only available for services that are not covered by Medicare. Please see Section III.B.2.h, above, for information on Medicare-covered home health care.

6. MATERNITY CARE

The Plan covers the following maternity care services:

- Prenatal exams
- Diagnostic tests
- Diet regulation
- Prenatal genetic testing
- Post-partum care
- Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If the inpatient stay is less than 48 hours (or 96 hours in the case of a cesarean delivery) the Plan will cover at least one home visit by a registered nurse or certified nurse midwife.
- Nursery charges for routine services provided to a healthy newborn.

7. HEARING AIDS

A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person's hearing.

The Plan covers hearing aids up to a maximum of $1,700 in a two calendar year period at 100% for the first $500 and 80% for the next $1,500 per Member**,** for Members ages 22 and older.

Please see Section III.C.7, of this Handbook, titled "Speech, Language and Hearing Services", for information regarding services rendered by Providers.

Please see Section III.C.11, of this Handbook for hearing aid coverage for Members up to the age of 22.

RELATED EXCLUSIONS:

- Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.
- No back-up, or spare, hearing aids will be covered.

8. CARDIAC REHABILITATION

The Plan will provide coverage, less any payments made by Medicare, for Medically Necessary inpatient and outpatient cardiac rehabilitation. Cardiac Rehabilitation is a multidisciplinary treatment of persons with documented cardiovascular disease. It may be provided in a Hospital or outpatient setting, and must meet standards promulgated by the Commissioner of Public Health, including, but not limited to, outpatient treatment initiated within 26 weeks after the diagnosis of the disease.

9. HUMAN LEUKOCYTE ANTIGEN TESTING

The Plan will provide coverage, less any payments made by Medicare, for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability. Such coverage will cover the costs of testing for A, B, or DR antigens, or any combination thereof, consistent with the guidelines, criteria, and rules or regulations established by the Massachusetts Department of Public Health.

10. FAMILY PLANNING SERVICES AND INFERTILITY TREATMENT

a. Family Planning Services

The Plan covers, less any payment made by Medicare, the following family planning services:

- Annual gynecological examination
- Family planning consultation
- Pregnancy testing
- Voluntary sterilization, including tubal ligation.
- Voluntary termination of pregnancy
- Contraceptive monitoring
- Genetic counseling
- Vasectomy

RELATED EXCLUSIONS:

- Reversal of voluntary sterilization

b. Infertility Treatment

Infertility is a medical condition defined as the inability of a presumably healthy individual to conceive or produce conception during a period of one year.

Medicare does not cover most infertility treatments. Infertility is defined as the inability of a woman age 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to six months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or six month period, as applicable.

The Plan covers the following infertility treatments:

- Consultation and evaluation
- Laboratory tests
- Artificial insemination (AI), including related sperm procurement and banking
- The Plan also covers up to a total of five cycles of advanced reproductive technologies (ART) when Medically Necessary. Advanced reproductive technologies includes in-vitro fertilization including embryo placement (IVF-EP), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intra-cytoplasmic sperm injection (ICSI), and donor egg procedures, including related egg and inseminated egg procurement, processing and banking

Important Notice: HPHC uses clinical guidelines to evaluate whether the use of ART is Medically Necessary. If you are receiving care for infertility, HPHC recommends that you review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38723.**

11. SMOKING CESSATION

The Plan covers treatment for tobacco dependence/smoking cessation. The following services are covered:

- Telephonic or face-to-face counseling. Face-to-face counseling may be completed in either individual or group sessions.
- FDA-approved prescription medications for the treatment of smoking cessation, with limitations.

Pharmacy items are subject to the prescription Copayment listed on your ID card.

IV. EXCLUSIONS FROM COVERAGE

A. No benefits will be provided by the Plan for any of the following:

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in this *Benefit Handbook*, the *Schedule of Benefits* or the *Prescription Drug Brochure*.
2. Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.
3. Any product or service obtained at an unapproved hospital (or other facility) if Medicare requires that a service be provided at a Hospital (or other facility) specifically approved for that service. This exclusion applies to weight loss (bariatric) surgery; liver, lung, heart heart-lung pancreas and intestine transplants; and any other services Medicare determines must be obtained at a Hospital (or other facility) that has been specifically approved for a specific service to be eligible for coverage by Medicare.
4. Any product or service that is provided to you after the date on which your enrollment in the plan has ended.
5. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")
6. Any products or services received in a hospital not certified to provide services to Medicare beneficiaries, unless the hospital is outside the United States, and you are experiencing a Medical Emergency.
7. Any product or service for which no charge would be made in the absence of insurance.

B. No Benefits will be provided by the Plan for any of the following unless they are covered by Medicare Parts A or B:

1. Any product or service that is not Medically Necessary.
2. Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or laws of similar purpose.
3. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
4. Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.
5. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")
6. Private duty nursing unless specifically listed as a Covered Service in your *Schedule of Benefits*.
7. Chiropractic care. (Note that Medicare provides limited benefits for chiropractic services to correct a sublaxation of the spine.)
8. Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.
9. Rest or Custodial Care.
10. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses. (Note that Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery.)
11. Acupuncture, aromatherapy, alternative medicine biofeedback, massage therapy (including myotherapy), sports medicine clinics, treatment with crystals.
12. Routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes.

13. Foot orthotics, except as required for the treatment of severe diabetic foot disease.
14. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.D.4. for the coverage provided for wigs)
15. Dental Services, except the specific dental services listed in your *Schedule of Benefits* and this *Benefit Handbook*. This exclusion includes, but is not limited to: (a) dental services for temporomandibular joint dysfunction (TMD); (b) extraction of teeth, except when specifically listed as a Covered Service; and (c) dentures, except that (1) the Plan will cover the Medicare Coinsurance and Deductible amount for any Dental Service that has been covered by Medicare and (2) the Plan will cover the limited additional dental services covered by the GIC. (Please see the Glossary for the definition of "Dental Services.")
16. Ambulance services except as specified in this *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.
17. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.
18. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
19. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.
20. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Coinsurance and Deductible amounts for professional services or surgery covered by Medicare for the treatment of obesity.)
21. Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.
22. Planned home births.
23. Devices or special equipment needed for sports or occupational purposes.
24. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Service under this *Benefit Handbook*.
25. Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.

V. REIMBURSEMENT AND CLAIMS PROCEDURES

A. INTRODUCTION

This section explains how to obtain payments for Covered Services from the Plan. Because Plan benefits generally depend upon the coverage provided by Medicare, Providers must bill Medicare for services covered by Medicare before billing the Plan.

The Plan will usually cover benefits by making payments directly to service providers. However, there are times when the Plan will pay you (the Subscriber) instead. This might occur, for example, when you have already paid the Provider for a Covered Service or when a Provider does not accept Medicare assignment. In such cases, the Plan may pay benefits directly to you.

Claims will be paid minus the Copayment, if applicable, that is listed in your *Schedule of Benefits*. All payments by the Plan are limited to the Payment Maximum described in the Subsection J, below. You are responsible for any amount billed by a Provider that is in excess of the Payment Maximum**.**

Claims will be reviewed within 45 days of receipt. If a claim cannot be paid within that time, the plan will either notify the Subscriber (1) that additional documentation is needed or (2) that the claim is denied, in whole or in part, and the reasons for denial. If the Plan does not provide such notice, interest will be payable to the Subscriber at the rate of 1.5% per month (not to exceed 18% per year) on the amount of benefits payable, beginning 45 days after receipt of the claim. However, no interest will be payable on any claim that the Plan is investigating because of suspected fraud.

B. THE ADDRESS FOR SUBMITTING CLAIMS

All claims for benefits, except pharmacy and mental health and substance abuse claims, must be submitted to the Plan at the following address:

Medicare Enhance Claims
HPHC Insurance Company, Inc.
P.O. Box 699183
Quincy, MA 02269-9183

All claims for mental health and substance abuse services should be mailed to:

HPIC - Behavioral Health Access Center
C/O UBH
P.O. Box 31053
Laguna Hills, CA 92654-1053

Requests for the reimbursement of pharmacy expenses should be sent to:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Please see Subsection G, below, for information on filing pharmacy claims.

C. CLAIMS FOR SERVICES COVERED BY MEDICARE PART A (HOSPITAL COVERAGE)

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part A, also known as Medicare Hospital Insurance. Medicare Part A services include inpatient care received in hospitals, skilled nursing facilities (SNFs) and Religious Nonmedical Health Care Institutions (RNHCIs). Medicare Part A also covers hospice services and some home health care.

Use this procedure to file a claim for any inpatient service that is, or may be, eligible for coverage by Medicare Part A. See Subsections E ("Claims for Services Not Covered By Medicare") and F ("Claims for Services Received in a Foreign Country"), below, for information on how to file a claim for an inpatient service that is not covered by Medicare. To obtain benefits for services under Medicare Part A, please follow these steps:

1. Bill Medicare First. Providers should first submit claims for Medicare Part A services to Medicare. Medicare will either pay the claim, in whole or in part, or deny coverage. You will be sent a Medicare Summary Notice (MSN). The MSN states the payment made by Medicare and explains any amount that was denied.

2. Then Bill Medicare Enhance. After the Medicare Summary Notice (MSN) is received from Medicare, the Subscriber or Provider must send each of the following items to the Plan to the address listed above:
   i. A copy of the Medicare Summary Notice (MSN); and
   ii. A standard UB 92 claim form completed by the Provider. (If a completed UB 92 claim form cannot be submitted, please see below.)

If a completed UB 92 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Subscriber's name, the Subscriber's Plan ID. Provider's name and address, the Provider's Medicare identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim.

The Plan may require the submission of additional information on some claims.

D. CLAIMS FOR SERVICES COVERED BY MEDICARE PART B

This section explains the procedure to follow to obtain benefits for services covered by Medicare Part B, also known as Medicare Supplemental Medical Insurance for the Aged and Disabled. Medicare Part B covers most outpatient services including most physician care, diagnostic tests, outpatient surgery, outpatient mental health care, physical, occupational and speech-language therapy and durable medical equipment.

1. PROVIDER BILLING FOR PART B SERVICES

Health care professionals, such as physicians, and suppliers of health care equipment and supplies, may bill for Medicare-covered services using one of two methods. These are that a Provider may either (1) "accept assignment" or (2) "not accept assignment" from Medicare. The following information on these billing methods is provided, for informational purposes only, to assist you in understanding your medical bills and the coverage available from the Plan. Please see the Medicare publication, *Medicare and You* for additional information on assignment and the limits that apply to Provider charges.

a. The Assignment Method Under Medicare

If a Provider accepts assignment from Medicare, the Provider agrees that he or she will accept Medicare's approved (or "allowable") amount as payment in full for the service rendered. When a physician accepts assignment the physician may not bill for more than the Medicare allowable amount and Medicare will pay the physician directly.

When a Provider accepts assignment, physician payment generally works as follows: The Provider bills Medicare. Medicare pays the Provider directly and send you a Medicare Summary Notice (MSN) explaining the payment. Then, either you or the Provider files a claim with the Plan for the balance due the Provider. For most physician services the Plan covers any unmet Medicare Deductible amount and the 20% Medicare Coinsurance amount, minus any Copayment you owe.

b. The Non-Assignment Method Under Medicare

If a Provider does not accept assignment from Medicare, the Provider may charge you more than the Medicare-approved amount. If the Provider selects that option, Medicare will not pay the Provider directly. Medicare will pay benefits to you (the Subscriber) and you are responsible for paying the Provider.

When a Provider does not accept assignment, physician payment generally works as follows: The Provider bills Medicare. Medicare pays you (the Subscriber) and sends

you a Medicare Summary Notice (MSN) explaining the payment. In most cases, you then file a claim with the Plan. For most physician services the Plan covers any unmet Medicare Deductible amount and the 20% Medicare Coinsurance amount, minus any Copayment you owe. The 20% Coinsurance amount paid by the Plan is based on the Medicare-approved amount, not the Provider's actual charge. If the Provider charged you an amount in excess of the Medicare-approved amount, you are responsible for paying that excess to the physician.

2. BILLING THE PLAN

After Medicare has been billed and sent you a Medicare Summary Notice (MSN) for a Medicare Part B service, you or the Provider may file a claim with the Plan for any Copayment and Deductible amounts that have not been paid by Medicare. Since the Plan covers some services that are not covered by Medicare, you may also bill the Plan for services that Medicare has denied.

To file a claim with the Plan, the Subscriber or Provider must send each of the following items to the Plan to the address listed in Subsection B, above:

1. A copy of the Medicare Summary Notice (MSN); and
2. A standard CMS 1500 claim form completed by the Provider. (If a completed CMS 1500 claim form cannot be submitted, please see below.)

If a completed CMS 1500 claim form cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Subscriber's name, the Subscriber's Plan ID, the Provider's name and address, the Provider's tax identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim

The Plan may require the submission of additional information on some claims.

E. CLAIMS FOR SERVICES NOT COVERED BY MEDICARE

This section describes how to file a claim for a service that is not covered by Medicare. The Plan covers a number of services that are not covered by Medicare. These services are described in Sections III.C ("State Mandated Services") and III.D ("Additional Covered Services"), above, and in your *Schedule of Benefits*. In addition, professionals or institutions that are not eligible to bill Medicare may provide certain Covered Services under Section III.C of this Handbook.

Whenever possible, your Providers should first bill Medicare for the services you receive. Submission of a Medicare Summary Notice (MSN), even if Medicare denies coverage, will prevent delays in the processing of claims that might be eligible for Medicare coverage. To bill the Plan for a service that is not covered by Medicare, please follow the procedure outlined below. For Covered Services rendered outside the United States, please follow the procedures outlined in the next section (Section F).

To file a claim with the Plan for a service that is not covered by Medicare, the Subscriber or Provider must send each of the following items to the Plan to the address listed in Subsection B, above:

1. A copy of the Medicare Summary Notice (MSN), if one has been issued; and
2. A standard claim form, such as a CMS-1500 or UB 92 claim form, completed by the Provider. (If a completed CMS-1500 or UB 92 claim form cannot be submitted, please see below.)

If a standard claim form, such as a CMS-1500 or UB 92 claim form, cannot be submitted, most claims can be processed using an itemized bill from the Provider in place of the claim form. Such an itemized bill must contain the following: The Subscriber's name, the Subscriber's Plan ID, the Provider's name and address, the Provider's tax identification number, the date the service was rendered, the diagnosis and procedure codes for the service, and the dollar amount of the claim.

The Plan may require the submission of additional information on some claims.

F. CLAIMS FOR SERVICES RECEIVED IN A FOREIGN COUNTRY

To file a claim with the Plan for services received while traveling in a foreign country, the Subscriber must send the Plan an itemized bill for the service rendered to the address listed in Subsection B, above. The itemized bill must contain the following: The Subscriber's name, the Subscriber's Plan ID, the Provider's name and address, the date the service was rendered, a description of the service, and the amount of the claim.

The Plan may require the submission of additional information on some claims. The Plan may also require that the Subscriber provide an English translation of the itemized bill.

Payments for services provided outside the United States will be made only to the Subscriber. The Subscriber is responsible for paying the Provider.

G. PHARMACY CLAIMS

Please consult your *Prescription Drug Brochure* for the details of your coverage. As explained in that Brochure, you should only need to file a claim for the reimbursement of covered pharmacy expenses if you do not use a participating pharmacy. In that event, you will have to pay the retail price for the medication and submit a claim for reimbursement.

In order to process a claim for the reimbursement of pharmacy expenses you will need to submit a drug store receipt with the following information: (1) the Subscriber's name, (2) the Subscriber's Plan ID number, (3) the name of the drug or medical supply, (4) the NDC number, (5) the quantity purchased, (6) the number of days supply, (7) the date the prescription was filled, (8) the prescribing physician's name, (9) the name and address of the pharmacy, and (10) the amount paid. The Plan may require the submission of additional information to process some claims.

Requests for pharmacy reimbursement must be sent to:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Subscribers may contact the MedImpact help desk at 1-800-788-2949 for assistance with pharmacy claims.

H. ASSIGNMENT OF BENEFITS

Subscribers may assign payments by the Plan to Providers by signing the appropriate section of the Provider's claim. The Plan will pay the Provider directly if benefits are assigned. If the Subscriber does not assign benefits to the Provider, the Plan will make payment for Covered Services to the Subscriber. The Subscriber will then be responsible for paying the Provider.

I. TIME LIMIT FOR FILING CLAIMS

All claims received from Providers or Subscribers for Covered Services must be submitted to the Plan at the address above within two years of the date of service, or the date of discharge if services were rendered on an inpatient basis. Whether the Subscriber or the Provider submits the claims, it is the Subscriber's responsibility to ensure that the claims are submitted within the above time frame.

J. THE PAYMENT MAXIMUM

The Plan limits the amount it will pay for any Covered Service to the "Payment Maximum." The Payment Maximum is as follows:

a. For Medicare-covered Items. If Medicare Part A or B covers a product or service, the Payment Maximum is the Medicare Coinsurance amount plus any unmet Medicare Deductible amount. The Medicare Coinsurance amount is the portion or percentage of the Medicare-approved payment amount for a product or service that a beneficiary is responsible for paying. (Note that any Plan payment will be reduced by any applicable Copayment specified in the Subscriber's *Schedule of Benefits*.)

   In some cases, providers may bill Medicare patients for amounts that exceed the Medicare-approved payment amount. Any amount that exceeds the Medicare-approved amount is the Subscriber's responsibility and is not payable either by Medicare or the Plan. Please see the discussion of "assignment" in the Medicare publication *Medicare and You* for information on limits that apply to Provider charges.

b. For Items Not Covered by Medicare. If Medicare Part A or B does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC Insurance Company (HPIC). If a Provider is under contract to HPIC, the Payment Maximum is the contracted rate for the service. If the Provider is not under contract to HPIC, the Payment Maximum is the amount, as determined by HPIC, which is within the normal range of charges made by health care Providers for the same, or similar, products or services in Boston, Massachusetts.

VI. APPEALS AND COMPLAINTS

This section explains the Plan's procedures for processing appeals and complaints concerning the benefits or services provided by the Plan. This section also explains the options available if an appeal is denied.

Please note that the appeal procedures stated below only apply to benefits of the Harvard Pilgrim Medicare Enhance Plan. If Medicare denies a claim, you must appeal to Medicare. Information on your Medicare appeal rights may be found on the Medicare Summary Notice, the document sent to you by Medicare that explains what action Medicare has taken on a claim.

A. HOW TO FILE AN APPEAL OR COMPLAINT

Any appeal or complaint may be filed in person, by mail, by FAX or by telephone.

Appeals or complaints, other than those concerning mental health or drug and alcohol rehabilitation services, should be submitted to:

Member Services Department
HPHC Insurance Company
1600 Crown Colony Drive
Quincy, MA 02169.

Telephone: 1-888-333-4742
FAX: 1-617-509-3085

Appeals or complaints concerning mental health or drug and alcohol rehabilitation services should be submitted to:

HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107

Telephone: 1-888-777-4742
FAX: 1-**888-881-7453**

B. ABOUT HPIC'S APPEAL AND COMPLAINT PROCEDURES

What are "Appeals" and "Complaints"? HPIC divides grievances into two types, "appeals" and "complaints" as follows:

- An appeal may be filed whenever a Subscriber is denied coverage by HPIC. This includes either the denial of a health service sought by a Subscriber or the denial of payment for a health service that a Subscriber has received.
- A complaint may be filed when a Subscriber seeks redress of any action taken by HPIC or any aspect of HPIC's services, other than a denial of coverage for health services.

Both appeals and complaints should be filed at the addresses or telephone numbers listed above in subsection 1.

Subscriber Representation. A Subscriber's authorized representative may file an appeal or complaint and participate in any part of the appeal or complaint process. Any notice referred to in this section will be provided to the Subscriber or, upon request, the Subscriber's representative.

A Subscriber's representative may be the Subscriber's guardian, conservator, agent under a power of attorney, health care agent under a health care proxy, family member or any other person appointed in writing to represent the Subscriber in a specific appeal or complaint to HPIC. HPIC may require documentation that a representative meets one of the above criteria.

Time Limit for Filing Appeals. A request for informal inquiry or appeal must be filed within 180 days of the date a service, or payment for a service, is denied by HPIC.

Appeals Involving Medical Necessity Determinations. Special rights apply to appeals involving medical necessity determinations. Such an appeal could involve a decision that a service (1) is not Medically Necessary, (2) is not being provided in an appropriate health care setting or level of care, (3) is not effective for treatment of the Subscriber's condition, or (4) is Experimental or Unproven. These include the right to appeal to an external review organization under contract with the Office of Patient Protection of the Department of Public Health. The procedure for obtaining external review is summarized below in subsection 6.

The Office of Patient Protection. The Office of Patient Protection of the Department of Public Health is the agency responsible for enforcing the Massachusetts laws concerning managed care grievance rights and for administering appeals to external review organizations. The Office of Patient Protection also enforces health care standards for managed care organizations, answers consumers questions about managed care and monitors quality-related health insurance information relating to managed care practices.

The Office of Patient Protection can be reached at:

Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site:
http://www.state.ma.us/dph/opp/index.htm

HPIC Report on Appeals and Complaints. HPIC will file an annual report on appeals and complaints with the Office of Patient Protection. After filing, the report for the prior year will be available to Subscribers upon request. A copy may be requested from the Member Services Department at the address or telephone number listed above in subsection 1.

Membership Required for Coverage. To be eligible for coverage by HPIC, a Subscriber must be duly enrolled under this Handbook on the date a service is received. A response to an informal inquiry or an appeal decision approving coverage will not be valid for services received after the termination of membership. However, payment may be made after the termination of membership for services received while membership was effective.

C. THE INFORMAL INQUIRY PROCESS

Most appeals and complaints result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, most appeals and complaints will first be considered in HPIC's informal inquiry process. However, the informal inquiry process will not be used to review a denial of coverage involving a medical necessity determination. Coverage decisions involving medical necessity determinations will be transferred directly to the formal appeal process described below in subsection 4.

During the informal inquiry process an HPIC Member Services representative will investigate an appeal or complaint and attempt to resolve it to the Subscriber's satisfaction. Whenever possible, the Member Services representative will provide the Subscriber with a response within 3 business days of receipt of the inquiry. This response will normally be communicated by telephone.

If the Member Services representative responds to an inquiry within 3 business days of receipt but the inquiry is not resolved to the Subscriber's satisfaction, the Subscriber may either file a formal complaint or appeal, as appropriate.

If the Member Services representative cannot respond to the inquiry within 3 business days, HPIC will transfer the inquiry to the formal appeal or formal complaint process, as appropriate.

D. THE FORMAL APPEAL PROCESS

HPIC's internal appeal process is available whenever a Subscriber is denied coverage by HPIC. This includes either the denial of a health service sought by a Subscriber or the denial of payment for a health service that a Subscriber has received. If a denial involves a medical necessity determination, an appeal may be filed immediately. All other appeals will be considered in the informal inquiry process, described above in subsection 3, before an appeal is filed.

How to File an Appeal. Appeals may be filed in person, by mail, by FAX or by telephone at the addresses or telephone numbers listed in subsection 1, above. After an appeal is filed, HPIC will appoint an Appeal Coordinator who will be responsible for the appeal during the appeal process.

Documentation of Oral Appeals. If an appeal is filed by telephone, an Appeal Coordinator will write a summary of the appeal and send it to the Subscriber within 48 hours of receipt. This time limit may be extended by written mutual agreement between the Subscriber and HPIC.

Acknowledgment of Appeals. Appeals will be acknowledged in writing within 15 days of receipt by HPIC. This time limit may be extended by written mutual agreement between the Subscriber and HPIC. No acknowledgment of an appeal will be sent if an Appeal Coordinator has previously sent a summary of an appeal submitted by telephone.

Release of Medical Records. Any appeal that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Subscriber or the Subscriber's authorized representative. (When signed by an authorized representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization for Release of Medical Information form is not provided when the appeal is filed, the Appeal Coordinator will promptly send a blank form to the Subscriber or the Subscriber's representative. If a signed Authorization for Release of Medical Information is not received by HPIC within 30 business days of the date the appeal is received, HPIC may issue a decision based on the information already in the file.

What are "Pre-Service" and "Post-Service" Appeals? HPIC divides appeals into two types, "Pre-Service Appeals" and "Post-Service Appeals" as follows:

- A "Pre-Service Appeal" requests coverage of a health care service that the Subscriber has not yet received.
- A "Post-Service Appeal" requests coverage of a health care service that the Subscriber has already received.

Time Limit for Processing Appeals. For Pre-Service Appeals, Subscribers will be provided with a written appeal decision within 30 days of the date the appeal was received by HPIC. For Post-Service Appeals, Subscribers will be provided with a written appeal decision within 30 business days of the date the appeal was received by HPIC. These time limits may be extended by mutual agreement between the Subscriber and HPIC. (Any such agreement must be in writing.) Any extension will not exceed 30 business days from the date of the agreement. HPIC may decline to extend the review period for an appeal if a service has been continued pending an appeal.

If an appeal requires the review of medical information, the date of receipt will be the date HPIC receives a signed Authorization for Release of Medical Information. If HPIC does not respond to an informal inquiry within 3 business days, the date of receipt will be the 4th business day following the date HPIC received the inquiry or the date HPIC receives the signed Authorization for Release of Medical Information, whichever is later. No appeal shall be deemed received until actual receipt of the appeal by HPIC at the appropriate address or telephone number listed in subsection 1, above.

If HPIC does not act on an appeal within 30 business days plus any extension of time mutually agreed upon in writing by the Subscriber and HPIC, the appeal will be deemed to be resolved in favor of the Subscriber.

Medical Records and Information. The Appeal Coordinator will try to obtain all information, including medical records, relevant to the appeal. Due to the limited time available for the processing of appeals, Subscribers may be asked to assist the Appeal Coordinator in obtaining any missing information or to extend the appeal time limit until such information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the appeal time limit, the appeal may be decided without the missing information.

Continuation of Services Pending Appeal. If an appeal is filed concerning the termination or reduction of coverage for ongoing treatment, such coverage will be continued through the completion of HPIC's internal appeal process if:

a. The service was authorized by HPIC prior to a request for an informal inquiry or the filing of an appeal;

b. The service was not terminated or reduced due to a benefit limit under this Handbook; and

c. The appellant is, and continues to be, enrolled in this Plan.

The Appeal Process. Upon receipt of an appeal, HPIC will review, investigate and decide an appeal within the applicable time limit unless the time limit is extended by mutual agreement.

The Appeal Coordinator will investigate the appeal and determine if additional information is required from the Subscriber. Such information may include medical records, statements from doctors, and bills and receipts for services the Subscriber has received. The Subscriber may also provide HPIC with any written comments, documents, records or other information related to the claim. Should HPIC need additional information to decide an appeal, the Appeal Coordinator will contact the Subscriber and request the specific information needed.

Appeals that involve a medical necessity determination will be reviewed by a health care professional in active practice in a specialty that is the same as, or similar to, the medical specialty that typically treats the medical condition that is the subject of the appeal. The health care professional conducting the review must not have either participated in any prior decision on the Subscriber's appeal or be the subordinate of such a person.

HPIC will make a decision following the investigation and review of the appeal. In making a decision, HPIC will consider the following review criteria: (1) the benefits and the terms and conditions of coverage stated in this Handbook; (2) the views of medical professionals who have cared for the Subscriber; (3) the views of any specialist who has reviewed the appeal; (4) any relevant records or other documents provided by the Subscriber; and (5) any other relevant information available to HPIC.

HPIC's decision of an appeal will be sent to the Subscriber in writing. The decision will identify the specific information considered in your appeal and an explanation of the basis for the decision with reference to the plan provisions on which the decision was based. If the decision is to deny coverage based on an Medical Necessity determination, the decision will include: (1) the specific information upon which the decision was

based; (2) the Subscriber's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (3) identification of any alternative treatment option covered by HPIC; and (4) the applicable clinical practice and review criteria information relied on to make the decision. The decision will also include a description of other options available for further review of the appeal. These options are described in Section 6, below.

No one involved in the initial decision to deny a claim under appeal will be a decision-maker in any stage of the appeal process. Subscribers have the right to receive, free of charge, all documents, records or other information relevant to the initial denial and appeal.

E. THE EXPEDITED APPEAL PROCESS

Subscribers may obtain expedited review of certain types of appeals. An expedited appeal may be requested if HPIC denies coverage for health services involving: (1) continued hospital care, (2) care that a physician certifies is required to prevent serious harm, or (3) a subscriber with a terminal illness. An expedited appeal will not be granted to review a termination or reduction in coverage resulting from (1) a benefit limit or cost sharing provision of this Handbook or (2) the termination of enrollment in the Plan.

Subscribers may request an expedited appeal – other than an appeal involving mental health or drug and alcohol rehabilitation services – by contacting HPIC orally or in writing at the following address or telephone numbers:

Member Appeals
HPHC Insurance Company
1600 Crown Colony Drive
Quincy, MA 02169

Telephone: 1-888-333-4742
FAX: 1-617-509-3085

Subscribers may request orally or in writing an expedited appeal that involves a mental health or drug and alcohol rehabilitation service by contacting UBH at the following address or telephone numbers:

United Behavioral Health
Appeals Department
100 East Penn Square, Ste. 400
Philadelphia, PA 19107

Telephone: 1-888-777-4742
FAX: 1-888-881-7453

HPIC will make a decision of an expedited appeal within 72 hours from receipt of the appeal unless a different time limit is specified below. If HPIC does not act on an expedited appeal within the time limits stated below, including any extension of time mutually agreed upon in writing by the Subscriber and HPIC, the appeal will be deemed to be resolved in favor of the Subscriber. HPIC's decision will be sent to the Subscriber in writing.

If you are filing an expedited appeal with HPIC, you may also file a request for expedited external review with the Massachusetts Office of Patient Protection at the same time. You do not have to wait until HPIC completes your expedited appeal to file for expedited external review. Please see the Section VI.F.2., titled "External Review" for information on how to file for external review.

The circumstances and procedures under which Subscribers may obtain an expedited appeal by HPIC are as follows:

a. Hospital Discharge

A Subscriber who is an inpatient in a hospital will be provided with an expedited review of any action by HPIC to terminate or reduce coverage for continued hospital care based upon the medical necessity of the hospitalization or the services provided. Any such appeal will be decided prior to the termination or reduction of HPIC coverage for the Subscriber's hospital stay. Coverage for services will be continued through the completion of the HPIC appeals process. HPIC will provide the Subscriber with written notification of the appeal decision prior to discharge from a hospital.

b. Services or Durable Medical Equipment Required to Prevent Serious Harm

An expedited review will be provided for appeals for services or durable medical equipment that, if not immediately provided, could result in serious harm to the Subscriber. "Serious harm" means circumstances that could (1) jeopardize the life or health of the Subscriber, (2) jeopardize the ability of the Subscriber to regain maximum function, or (3) result in severe pain that cannot be adequately managed without the care or treatment requested.

An expedited review will be provided in any case in which HPIC has denied coverage for a service or durable medical equipment if the physician recommending the treatment or durable medical equipment provides HPIC with a written certification stating that:

i. The service or durable medical equipment is Medically Necessary;

ii. A denial of coverage for the service or durable medical equipment would create a substantial risk of serious harm to the Subscriber; and

iii. The risk of serious harm is so immediate that the provision of the services or durable medical equipment should not await the outcome of the normal appeal process.

Any such certification must contain the name, address and telephone number of the certifying physician and his or her signature. Certifications may be delivered in person, by mail or by FAX at the addresses and telephone numbers listed above in this subsection. Upon receipt of a proper certification, HPIC will review the denial of coverage and provide the Subscriber with notice of the decision within 48 hours. A decision may take place earlier than 48 hours for durable medical equipment if (1) a request for such early reversal is included in the certification and (2) the physician's certification includes specific facts indicating that immediate and severe harm to the Subscriber that will result from a 48-hour delay.

c. Subscriber with a Terminal Illness

If a Subscriber with a terminal illness files an appeal of a denial of coverage, a decision will be made by HPIC within 5 business days of receipt of the appeal. A terminal illness is an illness that is likely to cause death within 6 months.

If a decision is made on appeal to deny coverage to a Subscriber with a terminal illness, HPIC will provide the Subscriber with a written decision letter within 5 business days of the decision. The decision letter will include:

1. A statement of any medical and scientific reasons for the denial; and
2. A description of any relevant alternative treatment, services, or supplies covered by HPIC.

If a decision is made on appeal to deny coverage to a Subscriber with a terminal illness, the Subscriber may request a meeting with an HPIC review committee to reconsider the denial. The meeting will be held within 10 days of request, unless the treating physician requests that it be held earlier. In such event, the meeting will be held within 5 business days. At the meeting the Subscriber and the committee will review the information previously provided in response to the Subscriber's appeal. The review committee will have authority to approve or deny the appeal. The review committee's decision will be the final decision of HPIC.

F. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the decision of your appeal, you may have a number of options for further review. These options may include (1) reconsideration of appeals that involve a Medical Necessity determination (as described in Section VI.B.) by an HPIC review committee, (2) external review by an independent organization appointed by the Office of Patient Protection, or (3) legal action. Below is a summary of these options.

1. RECONSIDERATION BY HPIC

If a Subscriber disagrees with a decision concerning an appeal that involves a Medical Necessity determination, the Subscriber may request reconsideration of such appeal by the HPIC review committee. The Subscriber must request reconsideration within 15 days of the date of HPIC's letter denying the appeal. Reconsideration is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the Handbook
- Decisions involving excluded services, except Experimental, Unproven, or Investigational services, and
- Decisions concerning Member cost sharing requirements

The Subscriber may request that the committee review the appeal based upon the documents and records in the appeal file without participating in the meeting. Alternately, the Subscriber, or the Subscriber's representative, may participate in the committee's meeting via telephone conference call to discuss the appeal.

Subscribers are welcome to provide HPIC with any additional documents or records concerning the Subscriber's appeal prior to the meeting. The HPIC review committee will provide the Subscriber with a written decision of their review of the Subscriber's appeal.

HPIC's reconsideration process is voluntary and optional. A Subscriber may request reconsideration by HPIC before or after seeking any other dispute resolution process described below. The only exception involves appeals that have been accepted by the Office of Patient Protection for external review. For example a Subscriber may request reconsideration of an appeal before seeking external review from the Office of Patient Protection, or the Subscriber may proceed directly to external review. A Subscriber may also request reconsideration if the Office of Patient Protection has determined that an appeal is not eligible for external review. However, HPIC will not reconsider an appeal that has been accepted for external review by the Office of Patient Protection.

Reconsideration by an HPIC review committee will not affect the Subscriber's rights to any other benefits. A Subscriber's authorized representative may act on their behalf, and file a request for reconsideration and participate in the review committee's meeting. On reconsideration, the HPIC review committee will make an impartial evaluation of the Subscriber's appeal based on the review criteria in subsection 4 above without deference to any prior decisions made on the claim.

HPIC will not assert that a Subscriber has failed to exhaust administrative remedies because the Subscriber has chosen not to seek reconsideration of an appeal that has been denied under the formal appeal process. HPIC also agrees that any statute of limitations or defense based on timeliness is tolled during the time period in which a request for reconsideration is pending.

No fees or costs will be charged by HPIC for reconsidering an appeal decision.

2. EXTERNAL REVIEW

Any Subscriber who wishes to contest a final appeal decision involving a medical necessity determination may request external review of the decision by an independent organization under contract with the Office of Patient Protection of the Department of Public Health. To obtain external review, a written request for external review must be filed with the Office of Patient Protection within 4 months of receipt of the written notice of the appeal decision by HPIC. A copy of the external review form will be enclosed with your notice from HPIC of its decision to deny your appeal.

A request for an external review must meet the following requirements:

1. The request must be submitted on the Office of Patient Protection's application form called, "Request for Independent External Review of a Health Care Decision." A copy of this form may be obtained by calling the Member Services Department at 888-333-4742. It may also be obtained from the Office of Patient Protection by calling 1-800-436-7757. In addition, copies of the form may be downloaded from the Department's website at http://www.state.ma.us/dph/opp/forms.htm.
2. The form must include the Subscriber's signature, or the signature of the Subscriber's authorized representative, consenting to the release of medical information.
3. A copy of HPIC's final appeal decision must be enclosed.
4. A fee of $25 must be paid. The Office of Patient Protection may waive this fee for extreme financial hardship.

The Office of Patient Protection will screen requests for external review to determine whether external review can be granted. If the Office of Patient Protection determines that a request is eligible for external review, the appeal will be assigned to an external review agency and the Subscriber (or Subscriber representative) and HPIC will be notified. The decision of the external review agency is binding and must be complied with by HPIC.

If the Office of Patient Protection determines that a request is not eligible for external review, the Subscriber (or Subscriber representative) will be notified within 10 business days, or in the case of requests for expedited review, 72 hours.

The Office of Patient Protection may be reached at:

Department of Public Health
Office of Patient Protection
99 Chauncy Street
Boston, MA 02111

Telephone: 1-800-436-7757
Fax: 1-617-624-5046

Web Site: http://www.state.ma.us/dph/opp/index.htm

The Office of Patient Protection may arrange for an expedited external review. A request for expedited external review must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the appeal decision would pose a serious and immediate threat to the health of the insured.

If the subject of an external review involves the termination of ongoing services, the Subscriber may ask the external review panel to continue coverage for the service while the review is pending. Any request for continuation of coverage must be made before the end of the second business day following receipt of the final adverse decision. The review panel may order the continuation of coverage if it finds that substantial harm to the Subscriber's health may result from the termination of coverage. The panel may also order the continuation of coverage for good cause. Any such continuation of coverage shall be at HPIC's expense regardless of the final external review determination.

G. THE FORMAL COMPLAINT PROCEDURE

A complaint may be filed when a Subscriber seeks redress of any action taken by HPIC or any aspect of HPIC's services, other than a denial of coverage for health services. All complaints will initially be considered through the informal inquiry process described above in subsection 3.

Complaints may be filed in person, by mail, by FAX or by telephone at the addresses or telephone numbers listed in subsection 1, above. A Member Services Representative will investigate each complaint and respond in writing.

Documentation of Oral Complaints. If a complaint is filed by telephone, a Member Services Representative will write a summary of the complaint and send it to the Subscriber within 48 hours of receipt. This time limit may be extended by mutual agreement between the Subscriber and HPIC. Any such agreement must be in writing.

Acknowledgment of Complaints. Written complaints will be acknowledged in writing within 15 days of receipt by HPIC. This time limit may be extended by written mutual agreement between the Subscriber and HPIC. No acknowledgment of a complaint will be sent if a Member Services Representative has previously sent a summary of a complaint submitted by telephone.

Release of Medical Records. Any complaint that requires the review of medical information must include a signed "Authorization for Release of Medical Information." This form must be signed and dated by the Subscriber or the Subscriber's authorized representative. (When signed by an authorized representative, appropriate proof of authorization to release medical information must be provided.) If an Authorization for Release of Medical Information form is not provided when the complaint is filed, a Member Services Representative will send a blank form to the Subscriber or the Subscriber's representative. If a signed Authorization for Release of Medical Information is not received by HPIC within 30 business days of the date the complaint is received, HPIC may respond to the complaint without the missing information.

Time Limit for Responding to Complaints. Subscribers will be provided with a written response to a complaint within 30 business days of the date the complaint was received by HPIC. This time limit may be extended by mutual agreement between the Subscriber and HPIC. Any extension will not exceed 30 business days from the date of the agreement. Any such agreement must be in writing.

If a complaint requires the review of medical records, the date of receipt will be the date HPIC receives a signed Authorization for Release of Medical Information. If HPIC does not respond to an informal inquiry within 3 business days, the date of receipt will be the fourth business day following the date HPIC received the informal inquiry. No complaint shall be deemed received until actual receipt of the complaint by HPIC at the appropriate address or telephone number listed in subsection 1, above.

If HPIC does not act on a complaint concerning benefits under this contract within 30 business days, plus any extension of time mutually agreed upon in writing by the Subscriber and HPIC, the complaint will be deemed to be resolved in favor of the Subscriber.

Medical Records and Information. The Member Services Representative will try to obtain all information, including medical records, relevant to a complaint. Due to the limited time available for processing complaints, Subscribers may be asked to assist the Member Services Representative in obtaining any missing information or to extend the time limit for response to the complaint until such information can be obtained. If information cannot be obtained by the 15th day following the receipt of the Authorization for Release of Medical Information and no agreement can be reached on extending the time limit for responding to the complaint, the Member Services Representative may respond to the complaint without the missing information.

VII. ELIGIBILITY AND ENROLLMENT

IMPORTANT NOTICE CONCERNING ENROLLMENT INFORMATION

PLEASE NOTE THAT THE PLAN MAY NOT HAVE CURRENT INFORMATION CONCERNING A SUBSCRIBER'S ENROLLMENT IN THE PLAN. THE GIC MAY NOTIFY THE PLAN OF ENROLLMENT CHANGES RETROACTIVELY. AS A RESULT, THE PLAN'S ENROLLMENT INFORMATION MAY NOT BE UP TO DATE. ONLY THE GIC CAN ACCURATELY CONFIRM MEMBERSHIP STATUS.

A. ELIGIBILITY

To be eligible to enroll, or continue enrollment, in the Plan, an individual must meet all the following requirements at all times:

1. Be enrolled in Medicare Part A and Part B and pay any premium required for continued enrollment;
2. Be enrolled through the GIC, which has entered into an agreement with HPHC Insurance Company (HPIC) for the enrollment of Subscribers in the Plan;
3 Be a resident of the United States or one of its territories; and
4. Be an individual for whom Medicare is primary to health benefits sponsored by the GIC. In general, these individuals are:
   a. Retired employees, their spouses or their survivors, who are insured by the GIC who are eligible for Medicare based on age;
   b. Retired employees, their spouses or their survivors, who are insured by the GIC who are eligible for Medicare based on disability; and
   c. Active or retired employees, their spouses or their survivors, who are insured by the GIC who: (i) are eligible for Medicare based on end stage renal disease (also known as "ESRD" or "permanent kidney failure"), and (ii) have passed the 30-month "coordination period" that begins when an individual becomes eligible for Medicare based on ESRD.
5. Not be enrolled in a Medicare Advantage plan under Medicare Part C.

The Plan must receive the premium amount due for the Subscriber's *Medicare Enhance* coverage from the GIC.

A dependent cannot be added onto a Subscriber's Medicare Enhance contract. However, a dependent spouse or child of a Subscriber who meets all of the eligibility requirements stated above may enroll in the Plan under a separate Contract.

The Plan must receive notice of enrollment from the GIC using Plan enrollment forms or in a manner otherwise agreed to in writing by the Plan and the GIC. The Plan must receive proper notice from the GIC of any Subscriber enrollment in, or termination from, the Plan no more than 90 days after such change is to be effective, unless otherwise required by law. Please see the GIC for information on effective dates or coverage, and Plan enrollment forms.

Please note that if an individual is re-employed by the Commonwealth of Massachusetts, the municipality, or the other entity that participates in the GIC on a part-time basis after retirement, the GIC must assume primary coverage for the individual (and his or her spouse) if the amount of work performed would be sufficient, based on hours, productivity or other criteria established by the GIC, to entitle an employee to coverage under the GIC's health plan for active employees. Such an individual (and his or her spouse) may not be deemed "retired" and is not eligible for enrollment in the Plan. The only exceptions apply to persons with ESRD.

B. ENROLLMENT

1. During the period established by the Plan and the GIC, individuals who meet the eligibility requirements may enroll in *Medicare Enhance* by submitting completed application forms for enrollment on the forms supplied by the GIC and the Plan.
2. Subscribers or applicants will complete and submit Plan enrollment forms and such other information as the Plan may reasonably request. Subscribers and applicants agree that all information contained in the enrollment form or other forms or statements submitted are true, correct, and complete. All rights to benefits are subject to the condition that all information provided to the Plan is true, correct, and complete.
3. By enrolling in the Plan, all Subscribers legally capable of contracting and the legal representatives of all Subscribers incapable of contracting, agree to all the terms, conditions, and provisions in this *Benefit Handbook*, including any amendments.

C. EFFECTIVE DATE OF ENROLLMENT

Subject to the payment of premiums and the Plan's receipt and acceptance of the completed enrollment form within 60 days of the enrollment date , an individual who meets the eligibility requirements stated above may be enrolled on any one of the following dates:

1. The date the individual retiree becomes enrolled in Medicare Part A and Part B;
2. The date the individual loses eligibility for health coverage through his or her spouse's employment, due to the spouse's death, loss of employment, reduction in hours, divorce, leave of absence, or retirement;
3. The date an active employee who is enrolled in Medicare Parts A and B based on ESRD completes the 30-month coordination period during which their non-Medicare health plan is the primary payer to Medicare; or
4. The GIC's Anniversary Date.

Except as otherwise provided by law, individuals are eligible for coverage under this *Benefit Handbook* as of the effective date unless the individual is a hospital inpatient on that date. If the individual is a Hospital inpatient on the effective date, coverage will begin on the individual's date of discharge.

D. IDENTIFICATION CARD

Each Subscriber will receive a *Medicare Enhance* identification card. This card must be presented along with the Medicare identification card whenever a Subscriber receives health care services. Possession of a Plan identification card is not a guarantee of benefits. The holder of the card must be a current Subscriber on whose behalf the Plan has received all applicable premium payments. In addition, the health care services received must be Covered Services. Fraudulent use of an identification card may result in the immediate termination of the Subscriber's coverage.

VIII. TERMINATION OF SUBSCRIBER'S COVERAGE

A. TERMINATION

The coverage of a Subscriber may be terminated as follows:

1. HPHC Insurance Company (HPIC) may terminate a Subscriber's coverage under the Plan for non-payment of premium by the GIC. Premium payments are due at the beginning of the coverage period. Thereafter, there is a ten-day grace period for the payment of each month's premium. HPIC will notify you in writing if your coverage is terminated for non-payment of premium by the GIC. In that event, HPIC will elect to follow one of two options: 1) continue your coverage up to the date you receive notice of termination, or 2) offer you continued coverage on a temporary basis.
2. HPIC may terminate a Subscriber's coverage under the Plan for misrepresentation or fraud, including, but not limited to:
   a. If the Subscriber permits the use of his or her *Medicare Enhance* identification card by any other person, or uses another person's card, the card may be retained by HPIC and coverage of the Subscriber may be terminated effective immediately upon written notice.
   b. If the Subscriber provides HPIC with any information that is untrue, inaccurate or incomplete, HPIC will have the right to declare this *Benefit Handbook* null and void or, HPIC, at its option, will have the right to exclude or deny coverage for any claim or condition related in any way to such untrue, inaccurate or incomplete information.
3. HPIC may terminate a Subscriber's coverage under the Plan if the Subscriber commits acts or physical or verbal abuse which pose a threat to Providers or other Subscribers and which are unrelated to the physical or mental condition of the Subscriber. HPIC will give the Subscriber notice at least 31 days before the date of termination.
4. HPIC may terminate a Subscriber's coverage under the Plan if the Subscriber ceases to be eligible under Section VII, above, including, but not limited to, the loss of Medicare Parts A or B. Coverage will terminate on the date on which eligibility ceased.
5. HPIC may terminate a Subscriber's coverage upon the termination or non-renewal of the GIC's Agreement under which the Subscriber is enrolled.
6. A Subscriber may terminate his or her enrollment under the Plan with the approval of the GIC. HPIC must receive a completed Enrollment/Change form from the GIC within 90 days of the date membership is to end.

B. REINSTATEMENT

A Subscriber's coverage will not be reinstated automatically if it is terminated. Reapplication is necessary.

C. CONTINUATION OF COVERAGE UNDER FEDERAL LAW

If you lose your GIC coverage because of bankruptcy, loss of dependency status (such as divorce), or termination of employment, you may be eligible for continuation of Employer Group coverage under the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please refer to the COBRA notices on page 46 for more detailed information.

D. CONTINUATION OF COVERAGE UNDER MASSACHUSETTS LAW

1. CONTINUATION FOLLOWING TERMINATION OF GROUP AFFILIATION

Provided premium is received by HPHC Insurance Company, coverage under this GIC Plan shall continue for a period of thirty-one days following termination of a Subscriber's affiliation with the GIC. No coverage under this provision shall be available during any portion of such thirty-one day period if (1) the Subscriber is entitled to similar health coverage elsewhere or (2) loses coverage under Medicare Parts A or B.

2. CONTINUATION FOLLOWING DEATH OF THE SUBSCRIBER

A Subscriber may elect to continue coverage under this GIC Plan in the event that coverage terminates due to death of the Subscriber who is the employee or retiree of the GIC. In such event, a spouse of the deceased Subscriber who is enrolled in the Plan on the date of death shall also be entitled to continuation of coverage under this provision.

Continued coverage under this provision shall only be available if an eligible surviving spouse (1) elects continuation of coverage in writing, (2) pays his or her required premium to the GIC within sixty days from the date coverage would otherwise terminate and (3) maintains coverage under Medicare Parts A and B. The

required premium will be the survivor share of the premium for the spouse of the deceased Subscriber.

For the surviving spouse of a retiree, continued coverage under the Plan will, in no event, continue beyond the earliest of:

a. The last day for which HPHC Insurance Company has received the required premium from the GIC;

b. The date the surviving spouse remarries; or

c. The date the GIC ceases to offer the Plan.

E. CERTIFICATES OF CREDITABLE COVERAGE

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Subscribers are entitled to a Certificate of Creditable Coverage, which verifies the most recent period of coverage under the Subscriber's Group. The certificate shows how many months of coverage a Subscriber has, up to a maximum of 18 months. It also shows the date coverage ended. The Plan will automatically send this Certificate to Subscribers upon termination of enrollment. However, Subscribers may contact the Plan by calling the Member Services Department at **1-888-333-4742** at any time within 2 years from the date coverage ended to request a free copy of their certificate from the Plan.

IX. WHEN YOU HAVE OTHER COVERAGE

A. COORDINATION OF BENEFITS (COB)

Medicare Enhance benefits are in addition to benefits provided under the Medicare program. No benefits will be provided that duplicate Medicare benefits. To the extent that the Subscriber also has health benefits coverage provided by another source, the Plan will coordinate coverage with the other payer, according to Massachusetts Coordination of Benefits regulations.

Benefits under this *Benefit Handbook* and *Schedule of Benefits* will be coordinated to the extent permitted by law with other sources of health benefits, including: motor vehicle insurance, medical payment policies, homeowners insurance, governmental benefits (including Medicare), and all Health Benefit Plans.

The term "Health Benefit Plan" means all HMO and other prepaid health plans, Medical or Hospital Service Corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits amounting to less than $100 per day.

Coordination of benefits will be based upon the reasonable and customary charge for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a Provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis for coordination. No duplication in coverage of services shall occur among plans.

When a Subscriber is covered by two or more Health Benefit Plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined before those of secondary plan(s) and without considering the benefits of secondary plan(s). The benefits of secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules shall decide which Health Benefit Plans are primary and secondary:

a. The benefits of the plan that covers the person as an employee or subscriber are determined before those of the plan that covered the person as a dependent.

b. The benefits of a plan, which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan, which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. If none of the above rules determines the order of benefits, the benefits of the plan which covered a person longer, are determined before those of the plan which covered a person for a shorter period of time.

   i. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

   ii. The start of a new plan does not include: (a) a change in the amount or scope of a plan's benefits; (b) a change in the entity which pays, provides or administers the plan's benefits; or (c) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

   iii. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a Subscriber of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

B. SUBROGATION

Subrogation is a means by which health plans recover expenses of services where a third party is legally responsible or alleged to be legally responsible for your Member's injury or illness.

If another person or entity is, or alleged to be, liable to pay for services related to your Member's illness or injury which have been paid for or provided by the GIC, the GIC will be subrogated and succeed to all rights to recover against such person or entity up to the value of the services paid for or provided by the GIC. The GIC shall also have the right to be reimbursed from any recovery a Member obtains from such person or entity for the value of the services paid for or provided by the GIC. The GIC will have the right to seek such recovery from, among others, the person or entity that caused or allegedly caused the injury or illness, his/her liability carrier or your own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. The GIC's right to reimbursement from any recovery shall apply even if the recovery the Member receives for the illness

or injury is designated or described as being for injuries other than health care expenses or does not fully compensate the Member for his or her damages, fees or costs. Neither the "make whole rule" nor the "common fund doctrine" apply to the GIC's rights of subrogation and/or reimbursement from recovery.

The GIC's recovery/reimbursement will be made from any recovery the Member receives from any insurance company or any third party and the GIC's reimbursement from any such recovery shall not be reduced by any attorney's fees, costs or expenses of any nature incurred by, or for, the Member in connection with the Member's receiving such recovery, and the GIC shall have no liability for any such attorney's fees, costs or expenses.

To enforce its subrogation and reimbursement rights under this Handbook, the GIC will have the right to take legal action, with or without your consent, against any party to secure reimbursement from the recovery of the value of services provided or paid for by the GIC for which such party is, or maybe alleged to be, liable.

Nothing in this Handbook shall be construed to limit the GIC's right to utilize any remedy provided by law to enforce its rights to subrogation under this Handbook.

C. MOTOR VEHICLE ACCIDENTS

When a Subscriber is involved in a motor vehicle accident, the Plan will coordinate benefits with the Subscriber's automobile insurance company. If a Subscriber is involved in a motor vehicle accident, the Subscriber must notify the attending physician(s) that the injuries are accident related. The Subscriber must also notify the Plan of the accident, the name and address of the Subscriber's automobile insurance carrier, and such other information as the Plan may reasonably request. Subscribers agree to complete the questionnaire provided by the Plan to obtain information regarding the accident.

D. DOUBLE COVERAGE

1. WORKER'S COMPENSATION/ GOVERNMENT PROGRAMS

If the Plan has information indicating that services provided to a Subscriber are covered under Worker's Compensation, their employer's liability policy or other program of similar purpose, or by a federal, state or other government agency, the Plan may suspend payment for such services until a determination is made whether payment will be made by such program. If the Plan provides or pays for services for an illness or injury covered under Worker's Compensation, their employer's liability policy or other program of similar purpose, or by a federal, state or other government agency, the Plan will be entitled to recovery of its expenses from the Provider of services or the party or parties legally obligated to pay for such services.

2. OTHER GOVERNMENT PROGRAMS

Except as otherwise provided by applicable law that would require the Plan to be the primary payer, the benefits under this *Benefit Handbook* will not duplicate any benefits to which Subscribers are entitled or for which they are eligible under any government program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for benefits provided by the Plan are payable to and may be retained by the Plan.

3. SUBSCRIBER COOPERATION

The Subscriber agrees to cooperate with the Plan in exercising its rights of subrogation and coordination of benefits under this *Benefit Handbook* and the *Schedule of Benefits*. Such cooperation will include, but not be limited to: a) the provision of all information and documents requested by the Plan, b) the execution of any instruments deemed necessary by the Plan to protect its rights, c) the prompt assignment to the Plan of any monies received for benefits provided or paid for by the Plan, and d) the prompt notification to the Plan of any instances that may give rise to the Plan's rights. The Subscriber further agrees to do nothing to prejudice or interfere with the Plan's rights to subrogation or coordination of benefits.

4. ASSIGNMENT

Coverage under this *Benefit Handbook* is not assignable by any Subscriber without the written consent of the Plan.

X. MISCELLANEOUS PROVISIONS

A. COMMENCEMENT AND DURATION OF BENEFITS

1. Except when an individual is hospitalized on the date of enrollment, all benefits under the Plan begin at 12:01AM on the effective date of enrollment. No benefits will be provided for any services rendered prior to the effective date of enrollment. If the individual is a Hospital inpatient on the effective date of enrollment, coverage will begin as of the individual's date of discharge.
2. No benefits will be provided for services rendered after coverage under this *Benefit Handbook* is terminated, unless the Subscriber is receiving inpatient hospital care covered under Medicare Part A on the date of termination. In such case, benefits under the Plan will be provided for Medicare Coinsurance and Deductible amounts for services covered by Medicare Part A up to the date of discharge, but in no event for longer than thirty (30) days after the date of termination. No benefits will be provided after the date of termination for any service that is not covered under Medicare Part A.
3. In computing the number of days of inpatient care benefits under the Plan, the day of admission will be counted but not the day of discharge. If a Subscriber remains in a Hospital, Skilled Nursing Facility, or other facility, for his or her convenience beyond the discharge hour, any additional charge will be the responsibility of the Subscriber.

B. TERMINATION AND MODIFICATION OF BENEFIT HANDBOOK

This *Benefit Handbook,* the *Schedule of Benefits,* and the *Prescription Drug Brochure* may be amended by the Plan upon 60 days notice to the GIC or as otherwise stated in an agreement between the Plan and the GIC. Subscribers will be given written notice of any material changes in covered benefits. Amendments do not require the consent of Subscribers.

This *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* and any riders or amendment thereto, are the entire contract between you and the Plan and, as of the effective date of this *Benefit Handbook*, supersede all other agreements between you and the Plan. The *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* and any riders or amendment thereto, can only be modified in writing by an authorized office of the Plan. No other action by the Plan, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of the *Benefit Handbook*, the *Schedule of Benefits*, the *Prescription Drug Brochure* and any riders or amendments issued by the Plan.

HPIC may terminate this *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure* by giving written notice to the GIC at least 60 days before the Contract Anniversary Date or as otherwise stated in an agreement between the Plan and the GIC.

C. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

The Plan uses clinical review criteria and guidelines to make fair and consistent utilization management decisions. Criteria and guidelines are developed in accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least biennially, or more often if needed to accommodate current standards of practice.

The Plan uses the nationally recognized InterQual criteria to review elective surgical day procedures and services provided in acute care hospitals. InterQual criteria are developed through the evaluation of current national standards of medical practice with input from physicians and clinicians in medical academia and all areas of active clinical practice. InterQual criteria are reviewed and revised annually.

Criteria and guidelines used to review other services are also developed with input from physicians and other clinicians with expertise in the relevant clinical area. The development process includes review of relevant clinical literature and local standards of practice.

The Plan's Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service. Clinician Advisory Committees work in collaboration with Medical Management leadership to develop and approve utilization review criteria.

D. RELATIONSHIP TO MEDICARE COVERAGE

As described in Section III, above, the Plan covers the Medicare Deductible and Coinsurance amounts for all

services covered by Medicare Parts A and B. If a benefit is added to the Medicare program, that benefit will be automatically added to the plan on the effective date of the benefit, subject to the terms of the contract between HPHC Insurance Company and the GIC.

The Plan reserves the right to communicate with Medicare about whether a Medicare coverage decision has been properly made for any reason, including, but not limited to, suspected fraud. However, the Plan is not required to do so in any case. Any decision by Medicare to cover, or not to cover, a product or service, is entirely the decision of Medicare. The Plan will not conduct utilization review of any charge for which Medicare has made a final decision to provide coverage.

E. UTILIZATION REVIEW PROCEDURES

The Plan may conduct utilization review of any product or service covered under the Plan that is not covered by Medicare, including a product or service for which Medicare coverage has ended for any reason. The goal of such review is to evaluate the Medical Necessity of selected health care services and to facilitate clinically appropriate, cost-effective management of Subscribers' care. The Plan uses the following utilization review procedures:

- Concurrent utilization review of admissions to Hospitals and extended care facilities, and skilled home health services. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of a determination to approve additional services, the Plan will notify the Provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to the Subscriber and the Provider within one working day thereafter. In the case of an adverse determination, we will notify the Provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to the Subscriber and the Provider within one working day thereafter.
- Retrospective utilization review may be utilized in situations where coverage is requested for services that, in the judgment of the Plan, may not be Medically Necessary

Active case management and discharge planning is incorporated as part of the concurrent review process.

Subscribers who wish to determine the status or outcome of utilization review decisions should call Member Services toll-free at **(888) 333-4742**.

In the event of an adverse determination involving clinical review, your treating Provider may discuss your case with a Plan physician reviewer or may seek reconsideration of the decision. The reconsideration will take place within one working day of your Provider's request. If the adverse determination is not reversed on reconsideration, you may appeal. Your appeal rights are described in Section VI ("Appeals and Complaints"). Your right to appeal does not depend on whether or not your Provider sought reconsideration.

F. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS

The Plan covers medical devices, diagnostic, medical and surgical procedures and drugs as described in your *Benefit Handbook*, *Schedule of Benefits*, and the *Prescription Drug Brochure*. This includes new devices, procedures and drugs, as well as those with new applications, as long as they are not Experimental or Unproven.

The Plan has a dedicated team of staff that evaluates diagnostics, medical therapies, surgical procedures, medical devices and drugs. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. The team researches the safety and effectiveness of these new technologies by reviewing published medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.

G. CONSENT TO DISCLOSURE OF MENTAL HEALTH INFORMATION

The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of the Medical Necessity of mental health services will be made in consultation with a licensed mental health professional.

H. LEGAL ACTIONS AND PROVIDER MALPRACTICE

No legal action may be brought against the Plan based upon this *Benefit Handbook*, or related to benefits provided by the Plan, unless brought within two (2) years from the time the cause of action arises.

The Plan will not be liable to Subscribers for injuries, loss, or damage resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any Provider, any Hospital, or any other institution or person providing health care services or supplies to any Subscriber.

I. MAJOR DISASTER, WAR, OR EPIDEMIC

In the event of a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of the Plan, the obligations of the Plan under this *Benefit Handbook* will be limited to making good faith effort to provide benefits covered by this *Benefit Handbook*.

J. NOTICES

Any notice to a Subscriber may be sent to the last address of the Subscriber on file with HPHC Insurance Company (HPIC). Any notice to HPIC should be sent to the address listed on the back page of this *Benefit Handbook*.

K. GOVERNING LAW

The *Benefit Handbook*, *Schedule of Benefits* and *Prescription Drug Brochure* shall be interpreted in accordance with the laws of the Commonwealth of Massachusetts.

XI. GLOSSARY

The Plan follows the definitions adopted by the Medicare program in providing benefits for services covered by Medicare. The following terms, as used in this Benefit Handbook, will have the meanings indicated below:

Anniversary Date

The date agreed to by the Plan and the GIC upon which the yearly GIC premium rate is adjusted and benefit changes become effective. This *Benefit Handbook*, the *Schedule of Benefits*, and the *Prescription Drug Brochure* will terminate unless renewed on the Anniversary Date.

Benefit Handbook (or Handbook)

This legal document, including the Benefit Handbook, the *Schedule of Benefits*, and the *Prescription Drug Brochure* and any applicable riders or amendments which set forth the services covered by the Plan, the exclusions from coverage and the terms and conditions of coverage for Subscribers.

Benefit Period

A Benefit Period is a way of measuring your use of services under Medicare Part A to determine Medicare coverage and your benefits under this *Benefit Handbook*. A Benefit Period begins with the first day of a Medicare-covered inpatient Hospital stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a Hospital nor of a Skilled Nursing Facility (SNF). Generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital. The type of care actually received is not relevant. However, for purposes of determining when a Benefit Period starts and ends, you are an inpatient of a Skilled Nursing Facility only when your care in the Skilled Nursing Facility meets certain skilled level of care standards established by the Medicare program. Please refer to the definition of "Skilled Nursing Care."

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.

Coinsurance

Cost sharing amounts established by Medicare that Medicare beneficiaries must pay after any Medicare Deductible has been met. Coinsurance is usually a percentage. (For example, many services covered under Medicare Part B require beneficiaries to pay a 20% Coinsurance amount.) As used in this Handbook, "Coinsurance" also includes fixed dollar amounts established by Medicare that Medicare beneficiaries must pay for certain services. The Plan provides coverage for Medicare established Coinsurance amounts minus any Copayments required by the Plan.

Copayments

Cost sharing amounts established by the Plan that are payable by Subscribers for certain Covered Services under the Plan. Copayments are usually fixed dollar amounts payable at the time services are rendered or when billed by the provider. The Copayments that apply to the GIC's coverage are listed in the *Schedule of Benefits*.

Covered Services

Health care services or supplies for which benefits are provided under this *Benefit Handbook*. Covered Services are described in Section III of this *Benefit Handbook*, the *Schedule of Benefits* and the *Prescription Drug Brochure*.

Custodial Care

Personal care that does not require the continuing attention of trained medical personnel. Custodial Care services assist a person in activities such as mobility, dressing, bathing, eating, food preparation, including the preparation of special diets, and taking medications that usually can be self-administered.

Deductible

A Deductible is a dollar amount that is payable each calendar year for Covered Services before benefits are available under an insurance plan. The Plan provides coverage for Medicare Deductible amounts minus any Plan Deductibles or Copayments required by the Plan. Please see *Medicare and You* for information on Medicare's Deductibles.

Dental Services

Services furnished for the care, treatment, removal or replacement of teeth or the structures directly supporting teeth.

Durable Medical Equipment

Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. However, an institution may not be considered a Subscriber's home if it meets the basic requirements of a Hospital or Skilled Nursing Facility. Durable Medical Equipment includes items such as oxygen equipment, wheelchairs, hospital

beds and other items that are determined to be Medically Necessary.

Employer Group (or Employer)

An employer that has entered into an agreement with HPHC Insurance Company for the provision of *Medicare Enhance* benefits to eligible individuals. For this plan, the Employer is the GIC.

Experimental , Unproven, or Investigational

The Plan does not cover Experimental, Unproven, or Investigational drugs, devices, medical treatment or procedures. A service, procedure, device, or drug will be deemed Experimental, Unproven, or Investigational by the Plan for use in the diagnosis or treatment of a particular medical condition if any of the following is true:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.

The Plan will not determine that a product or service that is covered by Medicare is Experimental or Unproven if such determination would conflict with a National Coverage Decision or a local coverage determination issued the Centers for Medicare and Medicaid Services or its contractors.

(The) Group Insurance Commission (GIC)

The state agency that has contracted with HPHC Insurance Company, Inc. to provide health care services and supplies for the employees, retirees, survivors, and their dependents that it insures.

Home Health Agency

A Medicare-certified agency that provides Medically Necessary Skilled Nursing Care and other therapeutic services in your home.

Home Health Care Services

Medically Necessary health care services provided at a Subscriber's residence (other than a Hospital, Skilled Nursing Facility, rehabilitation facility, Religious Nonmedical Health Care Institution) rendered by a Home Health Agency. Home health services must be provided by an organization eligible to receive payment from Medicare.

Hospice

A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supporting services to terminally-ill people and their families.

Hospital

A Medicare-certified institution licensed by the state in which it is located, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services or, when used in connection with Massachusetts-mandated benefits, an accredited or licensed hospital. The term "Hospital" does not include a Skilled Nursing Facility, convalescent nursing home, rest facility or a facility for the aged that primarily provides Custodial Care, including training in routines of daily living.

HPHC Insurance Company, Inc (HPIC)

HPHC Insurance Company, Inc. is the company that underwrites the Plan. HPIC may also be referred to as "we," "us" and the "Plan."

Inpatient Mental Health Facility

An inpatient mental health facility is one of the following: a general Hospital licensed to provide Mental Health services; a facility under the direction and supervision of the Massachusetts Department of Mental Health; a private mental hospital licensed by the Massachusetts Department of Mental Health; or a substance abuse facility licensed by the Massachusetts Department of Public Health.

Licensed Mental Health Professional

A Licensed Mental Health Professional is one of the following Providers: a licensed physician who specialized in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social workers; a licensed nurse mental health clinical specialist; or a licensed mental health counselors. The benefits provided under Section III.C.1 ("Mental Health Care and Drug Substance Abuse Rehabilitation Services") may be provided by any Licensed Mental Health Professional, including an individual who is not eligible for payment by Medicare.

Medical Emergency

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Subscriber or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another Hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.

Medically Necessary

In the case of services eligible for coverage by Medicare, Medically Necessary means that the service is reasonable and necessary in accordance with Medicare criteria. In the case of services not eligible for coverage by Medicare, Medically Necessary means that the service that is consistent with generally accepted principles of professional medical practice as determined by whether: (a) it is the most appropriate supply or level of service for the Subscriber's condition, considering the potential benefit and harm to the individual; (b) it is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and (c) for a service that is not widely used, its use for the Subscriber's condition is based on scientific evidence.

Medicare

A program of health benefits established by federal law and administered by the Centers for Medicare and Medicaid Services (CMS). The Plan covers services in conjunction with a Subscriber's benefits under Medicare Parts A and B. (It does not cover services in conjunction with Medicare Advantage Plan under Medicare Part C or a prescription drug plan under Medicare Part D.) Unless otherwise stated, when term "Medicare" is used in this *Benefit Handbook* it refers to Medicare Parts A and B.

Medicare Part B Premium

The monthly premium paid by Medicare beneficiaries for coverage under Medicare Part B.

Medicare-Participating Provider

A Hospital, SNF, Hospice, Home Health Agency, any other facility identified by Medicare, or a physician or physician group that satisfies Medicare's conditions of participation and enters into a participation agreement with Medicare.

Outpatient Mental Health Facility

An Outpatient Mental Health Facility is one of the following: a licensed hospital; a mental health or substance abuse clinic licensed by the Department of Public Health; a public community mental health center; a professional office; or home-based services.

Payment Maximum

The maximum amount the Plan will pay for any Covered Service. The Payment Maximum is as follows:

a. <u>For Medicare-covered Items</u>. If Medicare covers a product or service, the Payment Maximum is the Medicare Coinsurance amount plus any unmet Medicare Deductible amount. The Medicare Coinsurance amount is the portion or percentage of the Medicare-approved payment amount for a product or service that a beneficiary is responsible for paying.

   In some cases, providers may bill Medicare patients for amounts that exceed the Medicare-approved payment amount. Any amount that exceeds the Medicare-approved amount is the Subscriber's responsibility and is not payable either by Medicare or the Plan. Please see the discussion of "assignment" in the Medicare publication *Medicare and You* for information on limits that apply to Provider charges.

b. <u>For Items Not Covered by Medicare</u>. If Medicare does not cover a product or service, the Payment Maximum depends upon whether the Provider is under contract to provide services to Subscribers of HPHC Insurance Company (HPIC). If a Provider is under contract to HPIC, the Payment Maximum is the contract rate for the service. If the Provider is not under contract to HPIC, the Payment Maximum is the amount, as determined by HPIC, that is within the normal range of charges made by health care Providers for the same, or similar, products or services in Boston, Massachusetts.

Prosthetic Devices

Prosthetic Devices replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of Prosthetic Devices are cardiac pacemakers, prosthetic lenses, breast prostheses, maxillofacial devices, colostomy bags and supplies, and prosthetic limbs.

Provider

A doctor, Hospital, health care professional or health care facility licensed and/or certified by the state or Medicare to deliver or furnish health care services. The term Provider includes but is not limited to: physicians, podiatrists, optometrists, nurse practitioners, nurse midwives, nurse anesthetists, physician's assistants, psychiatrists, psychologists, licensed independent clinical social workers, licensed nurse mental health clinical specialists, and licensed mental health counselors.

Skilled Nursing Care

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

1. Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
2. Must be provided directly by, or under the general supervision of, skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Skilled Nursing Facility (SNF)

A facility (or distinct part of a facility), which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or a facility for the aged, which primarily furnishes Custodial Care, including training in routines of daily living.

Special Services

Those services and supplies a facility ordinarily furnishes to its patients for diagnosis or treatment during the time the patient is in the facility. Special Services include:

1. The use of special rooms and their equipment, such as operating rooms or treatment rooms;
2. Tests and exams, including electrocardiograms, laboratory, and x-ray;
3. Use of special equipment on the facility premises, and the services of persons hired by the facility to operate the equipment;
4. Services by a person with whom the Hospital or Skilled Nursing Facility, public community mental health center, or similar facility has a contractual agreement, by salary or otherwise, in conjunction with the use of the equipment specified above;
5. Drugs, medications, solutions, and biological preparations;
6. Administration of infusions or transfusions and other charges for services related to the administration of infusions or transfusions, (excluding the cost of whole blood, packed red blood cells, and donor fees); and
7. Internal Prosthetic Devices or appliances (artificial replacements of part of the body) that are an integral part of an operation. This includes hip joints, skull plates, and pacemakers. You are also covered for breast prostheses following mastectomy and surgery for treatment of breast cancer as required by federal law. These items are covered by Medicare Part A.

Subscriber

An individual who (1) meets all applicable eligibility requirements for enrollment in the Plan, (2) is enrolled in the Plan through the GIC, and (3) for whom the premium been received by the Plan.

Schedule of Benefits

A document that accompanies this *Benefit Handbook* that summarizes the Subscriber's coverage under the Plan and states the Copayments, benefit maximums and any special benefits provided to the Subscriber by the GIC.

Surrogacy

Any procedure in which a person serves as the gestational carrier of a child with the goal or intention of transferring custody of the child after birth to an individual (or individuals) who is (are) unable or unwilling to serve as the gestational carrier. This includes both procedures in which the gestational carrier is, and is not, genetically related to the child.

Terminal Illness

A Terminal Illness is an illness that is likely to cause death within six months, as determined by a physician.

Urgent Care

Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

XII. APPENDICIES

APPENDIX A. GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA GENERAL NOTICE

The Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747
Boston, Massachusetts 02114

(617) 727-2310
Fax (617) 227-2681
TTY (617) 227-8583
www.mass.gov/gic

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA
GENERAL NOTICE

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.
You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage.**

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced;
- The insured dies;
- The insured becomes legally separated or divorced;
- The insured or insured's former spouse remarries;
- A covered child ceases to be a dependent under GIC eligibility rules;
- The Social Security Administration determines that the employee or a covered family member is disabled; or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa** or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit **www.healthcare.gov** or, in Massachusetts visit, **www.mahealthconnector.org**.

APPENDIX B. IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Important Notice from the Group Insurance Commission (GIC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NON_GIC MEDICARE PART D DRUG PLANS.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join A Medicare Part D Drug Plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Non-GIC Medicare Drug Plan?

- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored Harvard Pilgrm plan. If you are disenrolled from Harvard Pilgrim, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **www.socialsecurity.gov** or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have

Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage….

Contact the GIC (617) 727-2310, ext.1. **NOTE:** You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit WWW.MEDICARE.GOV
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at WWW.SOCIALSECURITY.GOV or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Updated: November 2015

APPENDIX C. NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

REQUIRED AND PERMITTED USES AND DISCLOSURES

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

OTHER PERMITTED USES AND DISCLOSURES: THE GIC MAY USE AND SHARE PHI AS FOLLOWS:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws**;**
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at www.mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617)-227-8583.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

> If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
>
> Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
>
> Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at HTTP://WWW.DOL.GOV/ELAWS/USERRA.HTM. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.

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APPENDIX E. MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM NOTICE (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP program. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information visit **www.healthcare.gov**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor electronically at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2016. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**GEORGIA** – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA** – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	
FLORIDA – Medicaid	**MONTANA** – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA** – Medicaid

Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
KANSAS – Medicaid	**NEVADA** – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone:1-785-296-3512	Medicaid Website: **HTTP://DWSS.NV.GOV**/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	
LOUISIANA – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
MAINE – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
OKLAHOMA – Medicaid and CHIP	**NORTH DAKOTA** – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OREGON – Medicaid	**UTAH** – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
PENNSYLVANIA – Medicaid	**VERMONT**– Medicaid

Website: http://www.dhs.pa.us/hipp Phone: 1-800-692-7462	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
RHODE ISLAND – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: www.eohhs.ri.gov Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premuim_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN** – Medicaid and CHIP
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
	WYOMING – Medicaid
	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other States have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
WWW.DOL.GOV/EBSA
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
WWW.CMS.HHS.GOV
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

YOU ARE RECEIVING THIS NOTICE AS REQUIRED BY THE NEW NATIONAL HEALTH REFORM LAW (ALSO KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

On January 1, 2014, the Affordable Care Act (ACA) was implemented in Massachusetts and across the nation. The ACA brought many benefits to Massachusetts and its residents, helping us expand coverage to more Massachusetts residents, making it more affordable for small businesses to offer their employees healthcare, and providing additional tools to help families, individuals and businesses find affordable coverage. This notice is meant to help you understand health insurance Marketplaces, which are required by the ACA to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. While you may or may not qualify for health insurance through the Health Connector, it may still be helpful for you to read and understand the information included here.

Overview: There is an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: **MAhealthconnector.org**, or for non-Massachusetts residents, **Healthcare.gov** or (1-800-318-2596; TTY: 1-855-889-4325).

What is the Massachusetts Health Connector? The Health Connector is our state's health insurance Marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) Code.

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector occurs every year. You can find out more by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

QUESTIONS?

*For more information about the Health Connector, please visit **MAhealthconnector.org** or call **1-877 MA-ENROLL** (1-877-623-6765 or TTY: 1-877-623-7773, Monday to Friday, 8:00 a.m. to 6:00 p.m.*

Does access to employer-based health coverage affect my eligibility for subsidized health insurance through the Health Connector?

An offer of health coverage from the Commonwealth of Massachusetts, as the employer, could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- **The Commonwealth of Massachusetts does not offer coverage to you**, or
- **The Commonwealth of Massachusetts offers you coverage, but:**
  - The coverage the Commonwealth of Massachusetts provides you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or
  - The coverage the Commonwealth of Massachusetts provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs)

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by the Commonwealth of Massachusetts please note that you will lose the employer contribution (if any) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes. Health Connector premiums have different tax treatment.

As part of considering whether the ACA and Marketplaces will affect you as an employee it is important to understand what the Commonwealth of Massachusetts offers you.

- The Commonwealth offers benefited employees health coverage through the Group Insurance Commission. To be eligible for GIC health insurance, a state employee must work a minimum of 18 ¾ hours in a 37.5 hour workweek or 20 hours in a 40 hour workweek. The employee must contribute to a participating GIC retirement system, such as the State Board of Retirement**,** a municipal retirement board, the Teachers Retirement Board, the Optional Retirement Pension System for Higher Education**,** a Housing, Redevelopment Retirement Plan, or another Massachusetts public sector retirement system (OBRA is not such a public retirement system for this purpose. Visit **www.mass.gov/gic** or see your GIC Coordinator for more information.
- Temporary employees, contractors, less-than-half time part time workers, and most seasonal employees are not eligible for GIC health insurance benefits. These employees **MAY** shop for health insurance through the Health Connector and may be eligible for advanced premium federal tax credits and/or state subsidies if their gross family income is at or below 400% Federal Poverty Level (which is approximately $46,000 for an individual and $94,000 for a family of four). Visit **www.MAhealthconnector.org** or call 1-877-MA-ENROLL for more information.

If there is any confusion around your employment status and what you are eligible for, please email **HEALTHMARKETPLACENOTICE@MASSMAIL.STATE.MA.US** or contact your HR department or GIC Coordinator.

QUESTIONS?

*For more information about the Health Connector, please visit **MAhealthconnector.org** or call **1-877 MA-ENROLL** (1-877-623-6765 or TTY: 1-877-623-7773, Monday to Friday, 8:00 a.m. to 6:00 p.m.*

Harvard Pilgrim
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cc 1512/ma/enh